

FORMATION OF THE VA CHICAGO HEALTH CARE SYSTEM

FIELD HEARING BEFORE THE SUBCOMMITTEE OVERSIGHT AND INVESTIGATIONS OF THE COMMITTEE ON VETERANS' AFFAIRS HOUSE OF REPRESENTATIVES ONE HUNDRED FIFTH CONGRESS

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FORMATION OF THE VA CHICAGO HEALTH CARE SYSTEM

THURSDAY, OCTOBER 16, 1997

U.S. HOUSE OF REPRESENTATIVES,
SUBCOMMITTEE ON OVERSIGHT AND INVESTIGATIONS,
COMMITTEE ON VETERANS' AFFAIRS,
Washington, DC.

The subcommittee met, pursuant to notice, at 9 a.m., in the Humboldt Field House, 1400 North Sacramento Boulevard, Chicago, IL, Hon. Ray LaHood presiding.

Also Present: Representatives LaHood, Evans, Gutierrez, and Davis.

OPENING STATEMENT OF HON. RAY LAHOOD, ACTING CHAIRMAN

Mr. LAHOOD. The hearing will come to order. Good morning, and welcome, all of you interested citizens and folks who are also going to be testifying.

My name is Congressman Ray LaHood. And I am sorry that Congressman Terry Everett, the chairman of the subcommittee, is not here. Congressman Everett is from Alabama, and unfortunately he became ill a day or so ago and was not able to come.

I had intended to come to this meeting and participate in the committee hearing, and I was asked to chair the committee this morning. I am from the central part of the State. Peoria, IL, is my home town, and I represent the 18th District. I am also a member of the full Veterans' Committee.

So I would like to just make a brief opening statement and then call on Congressman Evans, Congressman Gutierrez, and Congressman Davis for any statement they would like to make, and then we will go to our first panel.

It is a pleasure to be here in Chicago. This hearing by the Veterans' Affairs Subcommittee on Oversight and Investigations on the formation of the VA Chicago Health Care System is at the request of our colleagues, Congressman Evans and Congressman Gutierrez.

They have taken a great deal of interest and promoted this hearing, and we are guests today of Congressman Gutierrez, whose District we are presently in. And Congressman Davis has the adjoining District right next to Congressman Gutierrez.

I want to welcome the Illinois veterans and other stakeholders in Chicago's integration process who are here today for this long-anticipated hearing.

I believe that this hearing will add to the committee's knowledge about VA facility consolidation and integration because they are occurring all across the country and more are expected.

The Subcommittee on Health held a joint hearing with this subcommittee on medical facility integration this past July. The VA in Washington is still refining its guidance to regional network directors on how the integration process should operate.

And by the way, the term "facility integration" means the combining of two or more medical facilities into one functional organization to provide a coordinated continuum of health care to veterans.

We are working with the VA to improve health care for veterans by improving the way facility integrations are accomplished, and obviously there is a willingness on the part of the VA to improve the process and better address stakeholder concerns.

It must be recognized that facility integration under the best of circumstances involves difficult issues, and stakeholders have legitimate interests that concern them greatly.

Several of the Chicago area service organizations will present their views, as well as the Deans of the University of Illinois School of Medicine and Northwestern School of Medicine, VA officials, and a representative of the Service Employees International Union.

I would like to recognize now the ranking member of the full Veterans' Committee, Lane Evans, from Rock Island, for whatever statement he would like to make.

OPENING STATEMENT OF HON. LANE EVANS, RANKING DEMOCRATIC MEMBER, FULL COMMITTEE ON VETERANS' AFFAIRS

Mr. EVANS. Thank you, Mr. Chairman. I appreciate this opportunity to participate with you, and am pleased that you have come as far as from Peoria to be here with us today. The interests of the two down-staters, myself and Congressman LaHood, I think indicates our strong concerns about the VISN process itself as it is being applied here in Chicago as well as throughout the whole United States.

As a member of the Illinois delegation, I am concerned about possible changes in VA health care in the Chicago area as a result of integration at West Side and Lakeside. I want to understand how the integration process is going and what veterans are to expect of their health care system in the coming years.

I hope to hear from all parties concerned about how the Chicago system integration process is going. I also can assure everyone present that veterans have a real champion in the ranking member of our Subcommittee on Health, Congressman Luis Gutierrez, who has been tireless about continuing his commitment to keeping the dialogue between veterans, employees, trainees, and officials of the VA system here in Chicago.

In fact, at a recent hearing we held in Washington, he offered to buy all of us lunch if we came to join him here in Chicago, and that is why I am here today as well.

It goes without saying that our colleague, Danny Davis, also has been a real fighter for veterans and particularly here in the Chicago area, and we are pleased he could join us as well.

This July we had a hearing in Washington to examine facility integration throughout the whole VA system. We learned that there are a few things about the Chicago integration that make it especially tough, namely, that West Side and Lakeside have similar patient care missions, are similar sizes, are close together, and have active medical school affiliations that are important players in their hospitals. In hindsight, we should have expected this process to be harder than most throughout the country.

During July's hearing, we ended up talking about the process VA should use to coordinate their integrations and the benefits veterans might gain by integrating some VHA activities and facilities with our current funding environment. Some facilities have saved millions of dollars and retrenched this funding into increasing access to primary care and other care that veterans need.

Where the advantages to integrating services are less apparent, however, conflicts always seem to follow. I believe that this is the case in Chicago, where specific goals and benefits to various stakeholders have not been identified and the perceived losses to all parties are great.

The lesson I took away from that hearing is how important communicating this information is and involving those interested in making decisions when they clearly understand their choices. VA managers must offer basic guidance in the goals, directions, and reasons for change proposed, and then assure that veterans and other stakeholders enter into the decision-making process.

So I am pleased to join my colleagues today, and I think all of you can be assured that we are going to follow this beyond this hearing today. Thank you again, Mr. Chairman, for hosting the hearing.

Mr. LAHOOD. Let me introduce Congressman Gutierrez for whatever statement he would like to make, and thank him and his staff, and also the Chicago Park District, for making this facility available to us. And I know that Congressman Gutierrez and his staff have worked very hard to arrange for this hearing this morning.

OPENING STATEMENT OF HON. LUIS V. GUTIERREZ

Mr. GUTIERREZ. Well, thank you. I want to thank Congressman LaHood for being here with us in Chicago. Thank you for coming up.

Before I proceed, I also would like to recognize the commitment that Chairman Terry Everett has made to veterans of this country. It is unfortunate that he is ill and not with us, because obviously his commitment is well-established in the Congress of the United States.

I think that, of course, we had this hearing because Chairman Everett knows from his own experience back in Alabama that VA hospital integrations require congressional oversight, and more importantly, that veterans, and I underscore veterans, and other stakeholders affected by these integrations need to be heard in the process.

We should all be appreciative of Chairman Everett for convening this important hearing and allowing my friend, Mr. LaHood, Congressman LaHood, to sit in the chair in his place. My good friend, Congressman Lane Evans, also deserves our thanks for making

this field hearing a reality. I know of no better advocate for veterans than Lane. He is a tireless worker for veterans and a leader and a mentor for my colleagues and I on the Veterans' Affairs Committee.

He also has a good memory. I do recall mentioning at our hearing in July that if the committee came to Chicago, I would buy my colleagues lunch. I would like to say, however, that it was not so much a bribe as a promotion of the fine cuisine that we have here in Chicago.

Representative Davis, Danny, thank you for joining us on the committee today. As both the West Side and the Lakeside hospitals are in your District, your leadership and interest in this issue is both welcome and required for this hearing to achieve its goals.

While we are on the subject of goals, allow me to explain very quickly what I believe our goals should be. As you all know, the West Side and Lakeside hospitals are undergoing a very significant transformation that could affect—that will affect—the health care received by more than half a million veterans in Cook County and northern Indiana. The two hospitals have been administratively merged into VA Chicago.

Thirty-two task forces, examining every aspect of health care and support services provided by these two hospitals, have completed their work by submitting their recommendations to the integration coordination committee.

While much has been accomplished to forward the integration of these two facilities, many questions remain unanswered at this point. The most important questions, I believe, regard the individual health care needs of our veterans.

How will these service changes, from the kitchens to the inpatient rooms to the surgical units to outpatient clinics, affect the health care veterans receive? And what will the VA in Chicago look like in 2 months, 2 years, or longer, given these new realities? What can our veterans expect from the new VA?

Back in Washington we hear quite often from health care experts and VA officials about the future of the VA, and we are always debating budgets and deficits and shortfalls and costs.

But unless we actually go out and listen to the brave men and women the VA was created to serve and allow these courageous individuals to hear directly from VA officials and other affected parties, we are not really doing our job. We are not really serving the people we represent and the veterans who served in the military on our behalf.

In my conversations with veterans in my District, I have heard a number of concerns reading the integration process. Many veterans fear that integration will mean longer waits at VA hospitals and service reductions that will force them to travel farther to access the health care they have earned and deserve. Many veterans also do not believe that the integration process has been as fair and open to their concerns as it should be.

I am not convinced that veterans have had the complete role in the process that they deserve. Let me, however, underscore I do believe that Dr. Joan Cummings, the director of the Service Network 12, and specifically Dr. Joe Moore, the director of the VA Chicago, and Dr. Christopher Terrence, the chairman of the Integration Co-

ordinating Committee, have worked tirelessly and hard to improve the process to include the participation of veterans and other stakeholders, and they should be commended.

The affiliated medical schools certainly have begun to work cooperatively to improve their relationship with each other and the VA, and that is an excellent signal in the right direction. However, I remain concerned that the process is not open enough, and look forward today to opening it up somewhat further.

That is why I am particularly pleased today that we will receive testimony from all. Without the input of all, we cannot judge whether integration is a success or a failure. And we need to hear from veterans. Listening and learning from you is ultimately the chief objective of this hearing.

I also want to suggest to others in our audience that if you have questions or concerns, you can write them down and have them brought up to me so that I may pose them to different witnesses as time permits. Otherwise, with the approval of the chairman, I will have these questions submitted for the official hearing record and answered at a later date by our witnesses.

I make unanimous request, Mr. Chairman, that we do that.

Mr. LAHOOD. Without objection.

Mr. GUTIERREZ. I want to thank all of the people here today, our local veterans, all of those who work at the VA. You are all very important to us for your interest in this important issue. And lastly, to say the process may not have started out excellently, but the process is improving, and we are here to improve it further today.

Thank you so much, Mr. Chairman.

Mr. LAHOOD. Thank you, Congressman Gutierrez.

Congressman Davis.

OPENING STATEMENT OF HON. DANNY K. DAVIS, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF ILLINOIS

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

Let me first of all express my appreciation to you for taking your time to come down, up in this instance, really, from Peoria, to chair the meeting.

I would also like to express appreciation to the ranking member of the full committee, Congressman Evans, for the outstanding job that he has done in processing the activities of veterans' affairs in all aspects of veteran life, in all aspects of veteran activity.

I would certainly want to extend appreciations to Congressman Gutierrez for the role that he has played not only in protecting the rights and interests of veterans, but in terms of establishing this hearing and bringing the subcommittee to Chicago to take a hard look.

Although I am not a member of the Veterans' Affairs Committee, as Congressman Gutierrez indicated a moment ago, in my Congressional District there are three Veterans' Administration hospitals, Lakeside, West Side, and Hines. I guess we probably have more in the way of veteran resources than you would find in most Congressional Districts throughout the Nation. Therefore, we would obviously have a very keen interest.

My staff has been intimately involved and we have been intimately involved with the planning process, I guess from the very

beginning. And I would like to commend and compliment not only Mr. Moore and Dr. Cummings, but also the medical schools and hospitals as well as other stakeholders, for the process in which they have been engaged now for several months.

And while it perhaps started out murky, I think that significant progress has been made to the extent that we are delighted to know that rather than talking about, as people earlier were, the possible closing of one of the facilities, we are now talking about the integration of the facilities into a system that can provide in a most cost-effective way the kind of services that the veterans of our city and region need, should have, and have, in fact, earned.

So I am pleased to be here. I welcome you all. Thank you so much for coming. And I trust that when we finish, that the veterans throughout the region will be happy, satisfied, and well pleased with the kind of services and the kind of care that is being provided for them. So I thank you, Mr. Chairman.

Mr. LAHOOD. Thank you, Congressman Davis.

We will begin with Panel 1, and we will ask each person to take up to 5 minutes to summarize your statement. Your entire statement will be made a part of the record. We have a court reporter here. All testimony, all questions, and all answers will be made a part of the permanent record of this particular hearing.

We are delighted to welcome Mr. James Balcer, the Director of Veterans for the City of Chicago; Mr. Sol Griffin, Chairman, Minority Veterans Committee, past National Vice Chairman of Montford Point Marines, Mr. Robert Plante, Supervisor, National Service Office, Chicago disabled American Veterans, and Ms. Brenda Woodall, Business Representative of Local 73, Service Employees International Union.

And I would ask Mr. Balcer, if you would like to go first. And we will proceed in this direction: Each take 5 minutes with whatever statement you want. Your entire statement will be made a part of the record. And then we will ask questions following Ms. Woodall's statement.

Please proceed.

STATEMENT OF JAMES BALCER, DIRECTOR, VETERANS FOR THE CITY OF CHICAGO; SOL GRIFFIN, CHAIRMAN, MINORITY VETERANS COMMITTEE AND PAST NATIONAL PRESIDENT OF MONTFORD POINT MARINES; ROBERT P. PLANTE, SUPERVISOR, NATIONAL SERVICE OFFICE, CHICAGO DISABLED AMERICAN VETERANS; BRENDA WOODALL, BUSINESS REPRESENTATIVE OF LOCAL 73, SERVICE EMPLOYEES INTERNATIONAL UNION

STATEMENT OF JAMES BALCER

Mr. BALCER. Thank you, Mr. Chairman, Congressman Davis, Congressman LaHood, Congressman Gutierrez, Congressman Evans.

My name is James Balcer and I am a former Marine, Vietnam veteran, Director of Veterans for the City of Chicago.

Let me say first that I am honored to give testimony to this subcommittee on Oversight and Investigation.

I am a member of the Integration Coordination Committee for VA Chicago Health Care System. I have also been a patient at VA West Side since 1970. I have worked closely with VA Lakeside, West Side, North Chicago, Hines, and regional offices at 536 South Clark.

I have worked with patients and staff for over 8 years. As a member of the Integration Committee, I can say that this committee chaired by Dr. Terrence has been sensitive to the needs and concerns of patients and staff when integration has been needed.

The first question I have always asked is, how will integration affect the patient? Second, will any staff lose a job or position? As someone who has been a patient, I know how it is to take a long bus ride and stand in line and wait for treatment. I have also been unemployed.

The Integration Committee has been an open and fair process with vigorous debate and discussion when needed. To the best of my knowledge, there has not been interference from anyone outside the Integration Committee.

Let me close by saying that yes, integration of Lakeside and West Side is needed. However, the veterans and staff must be considered whenever integration occurs.

Mr. LAHOOD. Thank you. Mr. Griffin.

STATEMENT OF SOL GRIFFIN

Mr. GRIFFIN. Distinguished Committee, I am honored to have this opportunity to testify as the chairman of the Minority Veterans Steering Committee and past national president of Montford Point Marines.

Thank you for this opportunity to testify and speak as chairman of the Minority Veterans Steering Committee about the process of integrating the West Side and Lakeside Veterans Medical—

Mr. LAHOOD. Mr. Griffin, could you pull your microphone a little closer? Thank you, sir.

Mr. GRIFFIN. Thank you for this opportunity to testify and speak as chairman of the Minority Veterans Steering Committee about the process of integrating the West Side and Lakeside veterans' medical facilities in Chicago. I am also speaking as a veteran and the past national vice president of Montford Point Marines.

The Minority Veterans Steering Committee has been very concerned about the fate of the West Side VA Hospital. And you may know, I was actively involved in keeping this hospital open at a time when the VA considered closing this hospital to help reduce operating costs. We are certainly glad that never happened.

But I must say that we remain concerned that it could happen at some future date. Our concern is partly based on what we see happening so far with the facilities integration process.

We are concerned that so far we don't see an even-handed approach in the integration process. For example, the person who has been charged with integrating the two facilities is from Lakeside Hospital. Can a person who directs this process and is tied to one hospital really be objective in determining what resources and personnel go to which hospital?

With the input of the stakeholder committee, which I serve on, it shouldn't matter who directs the process. But the input of the

committee is often watered down or comes too late. For example, the committee has too often been presented with plans that have been approved beforehand by the director.

We are not provided with sufficient information on the integration process, how services will be integrated, how the changes will affect veterans, how much the changes will cost to implement, how much the hospitals will save, and how the Veterans' Administration will reinvest the savings to benefit veterans.

These are important questions, and the committee can't provide useful input without this information. In addition, the committee needs to have some clout in the process. Otherwise, we are little more than a rubber stamp for the director. There needs to be a clear definition of the authority of the committee and the director and how the two should work together.

We are concerned that the director may have more authority than he should in the process. We have heard many complaints and concerns from staff and veterans using West Side Hospital that the director tends to favor the Lakeside facility in making decisions about where services and personnel will remain and where they will be cut.

We are concerned about this because the West Side Hospital has a stronger record of serving minority veterans than the Lakeside Hospital. The West Side Hospital also was the first to have a women's veterans program.

What also concerns us is that we have heard from employees at West Side Hospital that are being intimidated or reprimanded about any complaints they have about the process. For example, a worker at the West Side Hospital recently wrote me a letter.

He said that when he wrote a letter to Senator Durbin, also a member of the stakeholder committee, the letter was sent to his supervisor instead. He felt intimidated by this and was concerned that there was not an open process to listen to the opinions of the staff and the veterans served by the hospital.

Several workers have reported that complaints are discouraged. If you speak up, you get fired. Some of them have told us—an employee who is also a veteran told us that he was afraid that if he spoke out about his concerns, he would lose his veterans' benefits. A former employee who left for another job wrote a letter about the integration process and signed it, name withheld for fear of reprisal.

Recently a Lakeside staffer was chosen as the chief of nursing staff over both hospitals despite the fact that a West Side staffer was preferred by the committee. The staff at West Side feels unable to comment about why the Lakeside staffer was chosen for fear of losing their jobs.

How can we effectively integrate these facilities if we can't hear from the very people who work at the hospitals and are served by them? How can we hope to get honest input if hospital workers feel intimidated in the process, if their letters and comments are misdirected? Who could freely provide comment in such an environment?

I recommend to you a pamphlet written by the GAO and presented in testimony on making changes in VA health care. The pamphlet is very interesting because it talks about lessons learned

from facility integration. One thing mentioned was the need to provide a detailed integration plan to stakeholders before any implementation begins.

What happens with our committee is that by the time we hear of any plans, things are already done. There needs to be more genuine input by the committee, and that means nothing should happen until the committee has approved plans.

Second, there needs to be mere objectivity in the decision-making process, more independent judgment that isn't tied to the interests of one hospital over the other.

Finally, we need to open the process so that those people who work in the hospitals or who are served by them feel free to comment about their feelings on the process of the integration.

I am not here on behalf of the Minority Veterans Steering Committee to argue against the cost reductions. We know that cost-cutting is part of reality for the health care of veterans, just like they are part of reality for the private sector.

But I am here to argue for a more fair and reasonable process, one that takes into account the needs of the veterans. The West Side Veterans' Hospital serves a population that does not have the financial resources to get medical care they desperately need. If the purpose of the facilities integration process is truly to serve the veterans, then let's look at what their needs are.

Thank you again for this opportunity to voice the opinions of the Minority Veterans Steering Committee and to urge you to make sure that the facilities integration process does not result in the closing of one of these hospitals, or an even distribution of services between the two hospitals. Thank you again.

Mr. LAHOOD. Thank you, Mr. Griffin.

Mr. Plante.

STATEMENT OF ROBERT P. PLANTE

Mr. PLANTE. Mr. Chairman and members of the subcommittee, on behalf of the 25,000 Illinois members of the Disabled American Veterans, I am pleased to present our views concerning the integration and consolidation planning of the Department of Veterans Affairs, VA Chicago Health Care System, Lakeside and West Side Divisions.

At this time, I would like to take this opportunity to commend Dr. Joan E. Cummings, Network Director, Veterans Integrated Service Network 12, for her concentrated efforts to provide quality health care services for all Chicago area veterans. Her tenacity in overcoming major obstacles to achieve this endeavor is in keeping with the highest traditions of the Veterans Health Administration.

We believe in order to continue to provide quality health care services to the Chicago area veteran population, the integration and consolidation of services at Lakeside and West Side divisions are necessary. We also believe it is essential to maintain both facilities to adequately care for this significant veteran population. The following information sets out the services provided at the Lakeside and West Side facilities.

Lakeside division is a 350-bed facility with 1,200 employees and a \$96 million budget and 300 volunteers. It provides both primary and tertiary care to approximately 460,000 veterans in Cook Coun-

ty, Illinois and Lake County, Indiana, provided treatment for 21,746 veterans in the fiscal year 1995, and attended to 6,600 inpatient admissions and 208,000 outpatient visitations.

The West Side division is a 435-bed facility with 1,570 employees and a \$123 million annual budget, providing primary and tertiary care to approximately 411,000 veterans in Cook County, Illinois. It provided treatment to 24,781 veterans in fiscal year 1995 and attended to 8,100 inpatient admissions and 280,000 outpatient visitations.

It is our understanding that the integration and reorganization efforts of the VHA are to reduce operating costs, improve access to care, enhance and standardize the quality of patient care, and to improve satisfactions of services. In our view, these are attainable goals. We also believe integration and consolidation of service is a practical approach to reaching these goals.

The formulation of the Management Assistant Council, the Stakeholders Advisory Group, and the veterans advisory council within the VISN provided for stakeholders organizations to become an integral part of the reorganization effort. This allowed for open lines of communication to acquire direct information and present feedback during the process. It also served to suppress the rumors regarding the closure of the West Side division.

During the initial planning stage of integration, veterans service organizations accepted an invitation to meet with the University of Illinois Medical School, the affiliate at the West Side division, and its consultant to discuss the rumored closure of West Side.

A rumor had been leaked to the local media prior to the formulation of the stakeholders advisory group. The VSOs made it clear that their concerns were focused on the continued availability of health care for local area veterans, insuring that no additional burden would be placed on veterans seeking necessary treatment.

Soon after the media leak, local union representatives from West Side contacted VSOs to express their concerns and ask for support to establish lines of communications. We advised these individuals of our primary concern and offered to forward their concerns to the Management Assistance Council.

VSOs then met with the General Accounting Office to express their views concerning the physical plant at West Side. The conversation focused on the VSOs' responsibilities to area veterans and the necessity of retaining West Side to serve the veteran population.

The DAV was and remains concerned by the lack of input from stakeholders initially with the formulation of the Management Assistance Council. We believe that future efforts must include the involvement of stakeholder organizations in the initial design process.

We believe that in the process of insuring across-the-board stakeholder involvement, the VISN entangled itself in a web of groups, committees, and councils, thereby generating initial confusion and suppressing stakeholder participation. Presenting an overall plan prior to implementation would have enhanced stakeholder participation.

In the beginning, communication with stakeholders was limited to one or two mediums. Efforts to utilize electronic mail, hot lines,

newsletters, and conference calls were none existent. We believe a more comprehensive communication plan would have averted the perceptions of impending closure of the West Side facility.

We believe it imperative to include stakeholders, affiliates, and the news media in the VHA's effort to communicate its plan and the processes necessary to achieve its objectives of quality health care.

In closing, we believe that major hurdles have been overcome and Chicago-area veterans will be the beneficiaries of quality health care services provided by both Lakeside and West Side divisions of the Chicago VA Health Care System.

Mr. Chairman, thank you for convening this hearing today, and thank you for your efforts on behalf of veterans residing in your Districts and throughout the Nation.

This concludes my statement. I will BE happy to answer any questions you or the committee members may have.

Mr. LAHOOD. Thank you, Mr. Plante.

Ms. Woodall, I am sorry if I mispronounced your name earlier. Please proceed.

Ms. WOODALL. Okay.

Mr. LAHOOD. Would you pull that microphone closer to you, please? Thank you.

STATEMENT OF BRENDA WOODALL

Ms. WOODALL. Good morning, Chairman, Congressmen. I come here today representing the members of SEIU Local 73 who work at the Lakeside and West Side facilities. I understand my time to speak is brief, so I would like to address three points regarding the VA hospital consolidation process: the process by which the consolidation of services has taken place thus far, the impact the consolidation has had on the workers of the facility, and the impact of the consolidation on the quality of patient care.

First, the process. Local 73, I was asked to sit in on meetings on the Integration Committee. I assumed the purpose of my involvement was to inject the concerns of workers into the decision-making process. I was wrong.

My voice, and therefore the voice of over 1,300 workers I represented was drowned out by the rest of the committee. I offered a proposal to address our concerns and was told that it would not be included in the final recommendation and to negotiate with the individual hospitals, which, as you know, does not make any sense at all.

The concerns I raised were not taken seriously, and as a result the consolidation has had an extremely negative effect on hospital personnel and the quality of patient care.

The impact on the workers, I would like to talk about secondly. The cutbacks on staff have been devastating. We used to have 200 people clean Lakeside/West Side VA. Since the consolidation, the same amount of cleaning has to be done with far less personnel.

It equates to about one person responsible for cleaning 33,000 square feet, where the national average is 15,000 square feet to be cleaned by one individual. I don't have to tell you what it means in terms of worker injuries and employee morale. And that doesn't

even get to the problem the consolidation has caused in terms of providing the best level of patient care possible.

This leads me to my third and most important concern, how this consolidation has impacted the patients. You can imagine what happens when you cut the cleaning staff. But what happens when you stop replacing administrative personnel and cut LPNs and nurses' aides, the people who provide the most direct patient care?

Well, the first thing that is affected is the entry point to service delivery. With bare bones administrative staff, the waiting time for patients has increased dramatically, and once they get in, the time that someone can spend caring for them is cut considerably. When staff are forced into a situation where they have to run from bed to bed, nobody wins.

The staff suffer from injuries and low morale because they are not able to give the best care possible, and patients suffer because they don't get the best care that is needed.

Veterans deserve to be treated with dignity. This plan was developed and implemented without input from those who give the care and those who receive the care. Although the process of consolidation has started, I think it would still be worthwhile for management to meet with workers and veterans to assess the damage already done and figure out ways to minimize the negative effects for the future.

I appreciate the opportunity to raise these concerns, and sincerely hope that what has happened here will serve as a lesson for others in the areas in which to be consolidated in the future. Thank you.

Mr. LAHOOD. Thank you. We will begin with questioning by Mr. Evans, and we will use the 5-minute rule. And then if we need to have a second round, we can do that.

Mr. EVANS. Mr. Chairman, I would like to ask all the veterans service organizations whether they have yet seen at this point any cost savings, increased patient access, or quality improvements since this integration process has started.

Anyone have any comments?

Mr. PLANTE. We certainly have seen a lot of cost savings based on the reduction of duplicative services at both Lakeside and West Side. And we believe that certainly is essential, you know, to the consolidation process and to achieve continued quality health care at both facilities.

Mr. EVANS. Anybody else like to—

Mr. GRIFFIN. I would agree, the same thing.

Mr. EVANS. Can you pull the microphone closer?

Mr. GRIFFIN. I would agree, the same as my colleague.

Mr. EVANS. All right. We came here very happy that things seem to be changing somewhat in terms of the dissemination of information to veterans' groups, yet the Montford Marines feel that they have not—if I am reading you right, sir—been involved in the decisions that are being made. At a point where you are asked to give some input, it has already got so much momentum, quite often, that you have no real input whatsoever.

Some other veterans' groups have indicated that they feel there has been better communication, but you haven't seen that at this point?

Mr. GRIFFIN. Well, we have seen some communication. But I think that my statement basically is based on what we hear from employees and veterans in terms of the—we are not against the process of integration. That is not our issue at all.

The only thing from the complaints that we get is how that the process is going. In reference to the intimidation and these kind of things, we are very concerned about that because we feel that regardless of how you feel about the process, you should be able to express your views without, you know, any concern of intimidation.

Now, when we get these complaints, we feel that we should speak about it, and hopefully that this committee, maybe that some of these complaints might not even be true. I don't know. But I think that it would be worth or hopefully that the committee would maybe look at some of these issues and investigate some of these things that we hear.

Now, we feel that how we got into it, actually, we weren't involved in the initial process. The Montford Point Marines were not. And I think—I have served on Congressman Gutierrez's Veterans' Affairs Committee, and how we got into it, after the press noted that there was a change in the health care system for these hospitals, we were not invited to participate.

And how we became a part was after that, and I was told that they didn't know anything about us even though we are a national veterans organization, the first blacks in the Marine Corps. And we were quite intimidated with that—that they had talked to all the other groups, in other words, American Legion, VFW, DAV, all of them.

But our organization is structured to do the same things that these groups do, and we feel that we were not—but since that time, when we got, I guess, maybe we forced our way in, basically, to be heard, we have been.

And I sit down—I have made the stakeholder meetings. I don't think I have missed any of them. I have sat with the advisory council. I see a lot of good things in the process. But this one issue that really disturbs me and disturbs the people that I represent is, let's bring it out, find out if these accusations are true, and if they are not true, so be it, and let's continue with the business. But we are concerned with that.

Mr. EVANS. I thought we were doing pretty good by having two Marines on the first panel, and a sailor as well. That is not bad for representation here today.

Let me ask you, Mr. Griffin, I don't understand. I was in the Marine Corps, so I understand a lot of the military acronyms, and the VA uses some acronyms. Are you—is your Veterans' Advisory Committee plugged into the Management Assistance Council, the Stakeholders Advisory Group, or the Veterans' Advisory Council?

Mr. GRIFFIN. Yes. I sit on the stakeholders and the advisory council.

Mr. EVANS. But you don't feel minority veterans—as chairman of the minority veterans group, that you have gotten the kind of input that you think you should?

Mr. GRIFFIN. No, sir. I think we have got some of the input. In fact, when this process first started, I was very reluctant. But I

have looked at the process and meeting with Dr. Cummings, and I see a lot of things that are happening are good.

The only thing that sort of still gives me a little concern about is the same thing that I am seeing, is that whenever they make these decisions, who makes the decisions? I don't feel that any decisions should be made by one individual, whoever they are.

And yes, we are concerned about that. And we feel that we are getting some input by me being a member of the stakeholders committee.

Mr. EVANS. Brenda, just one question. You referred to increases in patient waiting time. You are not talking about waiting in the clinics and waiting rooms; you are talking about inpatient waiting times for help for the individual patients when they need a procedure to be done or some other test to be carried out for them, somebody that is already in the hospital.

Ms. WOODALL. Both.

Mr. EVANS. Both?

Ms. WOODALL. With the down—with integration, what is happening is they are being considered to be one service, such as, say, X-ray. And with the moving of staff back and forth sometimes, which occurs, we don't have enough personnel to actually service the veterans.

So you have increased times for patients to do tests in-house as well as the waiting lines because of the staffing levels administratively even to get in to see a doctor, an RN, or what have you, or even with pharmacy lines have increased.

Mr. EVANS. All right. Thank you, Mr. Chairman.

Mr. LAHOOD. Congressman Gutierrez.

Mr. GUTIERREZ. Thank you, Mr. Chairman. And thank you to all of the members of the panel this morning. Welcome here.

I guess as I sit here and listen to the testimony, it seems as though for the most part people feel the process is improving, that it is going in the right direction. But we still have some hurdles, some objections that we have heard here this morning, some hurdles, some problems in streamlining this process.

If I hear you right, the Service Employees Union representing the employees feels that they are one stakeholder in the process, but that they are getting shut out and that they are not being properly heard within the group. Is that a correct—

Ms. WOODALL. Yes. I would say that is correct. I mean, there are times where we are made aware of certain circumstances. But often the decisions already are made and we are coming in at the back half of it.

And employees, you know, we are trying to explain what is going on and telling them it is getting better. I think the overall process is improving, but I think the problems came about in the first half where there wasn't that open line of communication so we can give people the support they need in order to be assured that they are going to be employed or that, you know, one hospital is not going to overrun the other hospital.

I think the lack of communication from the whole process has been a significant problem.

Mr. GUTIERREZ. So we started with a very murky, and Congressman Davis described, a muddled process of communication to one

that is improving but still leaves something to be desired. Because I—Mr. Balcer, I remember first of all saying to Mr. Balcer and Mr. Griffin, both of whom sit on my Veterans' Advisory Committee and have been such great help to me as a Congressman to understand. I want to thank you and all the other members that are here today. I want to thank both of you.

Jim, what do you think? I mean, you said earlier you were concerned about the veterans and you were concerned about the employees. From what you have seen, what can we do better?

Mr. BALCER. I would suggest, and I hear—if there is an issue of the veteran, how will the veteran be treated, and what is the time traveling? That is what my biggest concern is, because I remember to this day having to take a bus from 123rd and Normal to the tail end and spending hours on that bus, and then get in line and wait.

What I try to look at is, what is the time? How will the patient be affected? What are the employees—I don't want to see anyone lose their job. I don't want to see anyone put on the street. So that is what has always been my concern, and I have always tried to be a voice to those two groups, especially the veterans.

It is not nice to have to take a bus and then stand in line. And I will admit, yes, that at first there were problems with this process. But now it seems to be smoothing out. It is—and I brought along some information, some documentation, that we were given on each of the integration questions.

This is what we were given every time we were there. So the committee—the integration, speaking of the integration, was given ample information to go over these questions.

Mr. GUTIERREZ. Okay. And then in listening to you, Mr. Griffin, you—I am sorry—you are raising some concerns, legitimately so, that you have heard from different people and from different sources.

But you have also stated that you think it is going in the right direction. You think people are integrating more into the process and more are being heard. But there are still some people you think and some issues you think that need to be wrestled with and addressed?

Mr. GRIFFIN. Definitely so. I think the process, like you say, is going well compared to what it was when we started. And I think we all—as a veteran community, we know that we have to accept changes, not only to the process.

And I think that what I would like to see, you know, I hate to stand before this committee and to present these kinds of statements. Somehow I think that to clear the record in terms of things that I have voiced by opinion on, is I think it should be an even-handed process, is that there should be some sort of investigation to either prove that this is right or this is wrong.

But as far as the overall integration process, I think that what we see, even if there are some things basically we don't like but we know that we have to accept change because of the economic structure.

But for the veteran, we are very much concerned, and I would say that maybe if we look at both hospitals we are concerned about. But then when I look at the situation at the West Side, I

see the population of the homeless veterans and all these people who have to be served by that institution.

And I think that one of the biggest problems, maybe, that they have with the statements that I am making is that there is a lack of communication between the director and the staff or the veteran.

Mr. GUTIERREZ. I think, Mr. Plante, you put it probably as precise as could be in terms of giving an historical overview. Do you think there is room for improvement in terms of this communication, and if you do, where do you think that room for improvement might exist, given where we started and where we are at today?

Mr. LAHOOD. Could you use that large microphone, please? Thank you.

Mr. PLANTE. Again, Congressman, I believe that we need some prior planning. We need to involve all parties concerned, not only the VSOs and the affiliates, but also the news media, and ensure that they know what is going on. The employees, obviously, fall into that stakeholder category.

And we believe that if everyone would have been involved initially and prior to the formulation of all of the committees and councils and advisory boards, that the communication would have flown—would have flowed much easier, if you will. And being so, the communication problem would have at least brought itself down to a low roar.

What we saw was an initial conflict, initial panic, and phone calls were just pouring in to all the veterans' service organizations that are located in the regional office.

And we met to discuss what you should do to try to alleviate that problem. As to stakeholder participation in the initial plan, how are we going to look at this problem? How are we going to approach it? And how are we going to address the concerns that are going to be brought up in the initial processes of consolidation and integration?

Mr. GUTIERREZ. I think that maybe—and we will discuss this some more, and obviously we will have Mr. Moore and Ms. Cummings come up right after this panel and they will be able to answer some questions—but maybe if we could get some more information from them in terms of where we are going with the employees.

How many employees do they see being in the integration, so that we can have a sense of where we are going and work more collectively with the labor unions?

But I think if you knew where they were going, you could have a better sense of what the future—and you could have a better dialogue and discussion, and therefore ameliorate any issues and problems, and figure out a plan of how you are going to get there so that the employees aren't affected—I am sure there are—you know, people don't have to lose a job. People—there are different ways that you can go about reassessing and reevaluating your personnel and assigning them to different issues.

And I just want to say that I agree with Mr. Plante. You know, this process started out with so many accusations and so much finger-pointing because the process—I think the VA understands that, and I think they have made—from what I hear from all of you, because all of you agree on one thing, and I think that that is very

important, that it is heading in the right direction, that there is more communication and that there are room for improvement in that communication.

So I think that is light years ahead of where we were at one year ago. And so I am happy that you all came. And I want to just state for the record, Mr. Chairman, that I think we are working in the right direction.

I am happy that we are going to have Mr. Moore and Joe Cummings come up in the next panel, because I want to say one thing, and that is that I had a wonderful conversation with Mr. Moore.

And I know while some people still have some reservations because of this Lakeside/West Side thing, I think he has taken a lot of steps to make sure that there is a fair and equitable treatment in terms of his new—he is the new director. And he came from Lakeside, not West Side.

But I think that given his history and given where he has been at and his commitment to veterans, I am happy to see that those kinds of accusations have not been raised here today, because I think that he is trying to do a very, very good job in integrating everybody and to be fair.

And I am sure we will be able to raise to Mr. Moore some things that Mr. Griffin and Ms. Woodall have brought up here today so that we can better flesh this out. That is part of the process. And I look forward to hearing from Mr. Moore and Joan Cummings at the next panel. Thank you very much.

Mr. LAHOOD. Thank you. Mr. Evans, any further questions?

Thank you all very much for being here. I believe it was—did you want to say something?

Mr. BALCER. I just wanted to go on record as saying that I agree with Mr. Griffin. If there is any form of intimidation or retaliation, it should be investigated. It should be ferreted out, and let's get to the bottom of it to find out if it is reality or if it is false. Thank you, sir.

Mr. LAHOOD. Thank you. Thank you all very much.

It was suggested that we take Panel 3 next. Is that okay with—I believe that we will take Panel 3 now. Dr. Moss and Dr. Colten, if you could come forward, please.

Those large microphones are the ones that will amplify your voice. So if you will use those.

Dr. Gerald Moss is the Dean of the College of Medicine at the University of Illinois at Chicago, and Dr. Harvey Colten is the Dean of the—Vice President for Medical Affairs, Northwestern University Medical School.

If you would like to take 5 minutes to make a statement, your entire statement will become a part of the record. And then we will ask our members to ask questions. Whoever would like to go first may proceed.

STATEMENT OF GERALD S. MOSS, M.D., DEAN, COLLEGE OF MEDICINE, UNIVERSITY OF ILLINOIS AT CHICAGO; AND HARVEY R. COLTEN, M.D., DEAN, VICE PRESIDENT FOR MEDICAL AFFAIRS, NORTHWESTERN UNIVERSITY MEDICAL SCHOOL

STATEMENT OF GERALD S. MOSS, M.D.

Dr. MOSS. Good morning, Mr. Chairman, and distinguished members of the Veterans' Affairs Subcommittee on Oversight and Investigations. My name is Gerald Moss. I am professor of surgery and dean of the College of Medicine at the University of Illinois at Chicago.

Mr. LAHOOD. Let me just ask you to wait, sir. I wonder if those who are having conversations would step to the outside of the doors so that Dr. Moss may be heard by those who are in the room. Could we close the door back there, please?

Thank you very much. I am sorry. Would you mind beginning over? Thank you, Dr. Moss. We missed part of your opening statement.

Dr. MOSS. Good morning, Mr. Chairman, and distinguished members of the Veterans' Affairs Subcommittee on Oversight and Investigations. My name is Gerald Moss. I am professor of surgery and dean of the College of Medicine at the University of Illinois at Chicago.

I appreciate the opportunity to appear before you this morning and to update you on developments in the relationship of the VA Chicago Health Care System with the UIC College of Medicine.

First, I want to express my thanks and the appreciation of the university to Mr. Gutierrez, Mr. Davis, Mr. Evans, and Senators Moseley-Braun and Durbin, and to former Member of Congress Cardiss Collins, for their outstanding leadership on this issue.

I am convinced that their efforts have brought about many constructive developments in this evolving relationship, and have been of enormous value in meeting our joint responsibilities to provide care for veterans that is truly second to none.

I am particularly proud to note that the University of Illinois and Northwestern University were the first two universities to establish a direct and formal relationship with the VA Health Care System more than half a century ago.

All of us in health care are being challenged by enormous changes in the financing and delivery of health care, and many of those same changes are affecting the VA. We fully recognize that the VA must adapt and adjust to those new operational and fiscal realities, and I want to assure you that UIC is committed to working with the VA to make those changes in a way that benefits veterans and optimizes the educational environment of both institutions.

As you know, we have been concerned about the proposed changes in the VA system here in Chicago. Many of us have been working over the past year and more to ensure that any decisions to be made were driven by accurate and relevant data, and that all of the affected constituencies were appropriately involved, and that the best interests of veterans and those who care for them were foremost concerns.

The process to integrate services at Chicago VA, one established through your efforts and those of then-Secretary Jesse Brown approximately one year ago, have worked well. I am pleased to report to you today that the dean of the Northwestern University School of Medicine, Dr. Harvey Colten, and I have worked out an agreement that we are convinced will serve the VA, its patients, and our students well.

Specifically, we have agreed that we will together propose to the director of VA Chicago, Mr. Joseph Moore, a joint dean's committee made up of members from both medical schools and both divisions of VA Chicago to replace the existing two dean's committees.

We believe that this joint committee will assist VA Chicago to realize operational efficiencies, to preserve the high quality health care that our veterans deserve, and to maintain the superb educational and research environment afforded by the VA system.

In addition, UIC is working actively with VISN 12 to help it evaluate health care needs of veterans in this region. This is clearly a work in progress. But there are lessons in the Chicago experience that will be useful in other areas of the country as the VA strives to consolidate its facilities to reduce duplication and overlapping efforts.

I believe that a rational process for such consolidations would involve a number of steps I have listed in my written testimony. I would like to summarize those.

First, the VISN director must identify those areas in which duplication of effort seems likely and where geography might permit service consolidations.

Second, the stakeholders in existing facilities must be convened and a clear articulation of the problem must be presented. A mutually agreeable process must be established with adequate time to deliberate. Public discussion must occur.

Third, all the data necessary to make fair, balanced, and equitable decisions must be gathered, and appropriate consultations from a neutral third party is highly, highly desirable.

Finally, a durable oversight mechanism to insure that all parties are treated fairly should be in place.

In any undertaking of this complexity, mid-course corrections are inevitable. I would respectfully recommend that this committee consider these criteria carefully, which may well serve to guide VA mergers or consolidations across the United States.

There is one other area of concern to me and many of my fellow deans. The Veterans' Equitable Resource Allocation, known as VERA, is shifting money from VA systems in the northern tier of States to those in the southern tiers. We are concerned VERA does not take into account the health status of those veterans in the northern States, nor recognize that the majority of training programs, with their attendant higher costs, are located in these States.

I hope that the committee will objectively evaluate the effects of this new resource allocation system and make corrections if they are found to be necessary.

Mr. Chairman, I am grateful for your interest and leadership in this extremely important issue. The College of Medicine at the University of Illinois at Chicago, and I as a Navy Vietnam veteran my-

self, are quite proud of the relationship we have with our affiliated VA Medical Center. I welcome the opportunity to answer any questions you may have. Thank you.

[The prepared statement of Dr. Moss appears on p. 38.]

Mr. LAHOOD. Thank you, Dr. Moss.

Dr. Colten.

STATEMENT OF HARVEY R. COLTEN, M.D.

Dr. COLTEN. Thank you, Mr. Chairman, gentlemen, Mr. Evans, Mr. Gutierrez. I assume Mr. Davis is here.

I, too, am pleased to have a chance to speak with you this morning. I came into this process relatively late, and it sounds like it was a good time to come in. There were many difficulties early in this process. That is not a surprise. Integration of medical services require enormous amounts of reshifting of thinking, resources, and as well as activities.

We are involved in a process that medical services are going through throughout this country. And we are leading the way in this process in a complex situation where two academic medical centers have a longstanding relationship with the VA, as you have heard from Dr. Moss.

The cooperation that is developing between these two institutions, I believe, will not only facilitate the process, but will be sensitive to the stakeholders' concerns that we have heard about today.

I want to point out to you, as I did in my submitted testimony, that the environment within an academic medical center creates a kind of "sunshine culture," a culture in which the availability of data is wide open, where decisions can be data driven, where the best choice among difficult choices sometimes have to be made, and can be made in the presence of free and open information. That process has been taking place!

My experience thus far is that the leadership of the VISN under Dr. Cummings and Dr. Moore as director of Chicago VA, and Dr. Terrence's leadership in the integration committee, has been most commendable. I believe I have never seen anywhere, as fair an effort to take into account the views of widely disparate groups.

In the last analysis, not everyone will be happy with the solutions. But it seems to me, if the objective is the highest quality care at whatever cost savings we can accomplish, we have achieved the purpose by increasing the value of veterans' affairs and health care to veterans. Value, of course, is a product of quality and cost.

I believe from what we have heard today that, we must redouble our efforts to be sensitive to the stakeholders even though I believed we were doing a good job.

I think we have to take seriously what we have heard today; make an honest effort to hear out all the arguments, but then, as has been done so far (and I am impressed with it) make those decisions that seek the ultimate objective. If that objective is served, then I think all the veterans are served; the academic institutions are very supportive of that.

Dean Moss has indicated one of the several steps that we have taken to streamline the information processing and distribution so

that we can avoid errors of communication that occurred in the past; that is, the construction of a single dean's committee.

I believe that is not enough. We must do more. We must redouble our efforts. We are delighted that you are here to help us in that effort, and we thank you very much for the opportunity to speak with you this morning.

[The prepared statement of Dr. Colten appears on p. 42.]

Mr. LAHOOD. Thank you, Congressman Evans.

Mr. EVANS. Thank you, Mr. Chairman. I think I can speak for the entire Illinois delegation when I say we are so happy that you have come up with this compromise. There was a lot of effort put into it, I am sure, and we think this is definitely a step in the right direction.

Let me ask you, though: I have heard that medical programs require a certain number of patients, a so-called critical mass, to operate effectively. Are you always sure that the patient populations using the divisions of the Chicago VA comprise a critical mass? And that would be particularly a concern about surgery.

Dr. COLTEN. Yes, sir, when one is talking about surgery, in general, I believe that is true. There may be surgical subspecialties where consolidation is appropriate on that basis.

This is not simply an educational requirement. It is a requirement for skill maintenance. Surgeons who are not doing a sufficient number of procedures will, in fact, have their skills deteriorate to some extent. So these guidelines of service numbers include both quality of care issues as well as educational issues.

Dr. MOSS. Well, it is confounded in the surgical area by the fact that the surgeons tend to move back and forth between the VA and the university. So while there are ebbs and flows of surgical activity at the VA or the university, they tend to cancel each other out at the other side. So both of us watch those numbers pretty carefully, as do the department heads in those surgical areas.

And we are concerned about that, for sure, but at the moment I think the numbers are satisfactory.

Dr. COLTEN. Mr. Evans, if I might add: for example, at the Lakeside division, while there are 147 VA-employed physicians, there are 263 physicians from the Northwestern faculty who contribute their services, but their principal practice is at Northwestern Memorial Hospital. What Dr. Moss says is very well supported by the statistics.

Mr. EVANS. All right. Thank you, Mr. Chairman.

Mr. LAHOOD. Congressman Gutierrez.

Mr. GUTIERREZ. Thank you. Thank you very much, Dr. Moss, Dr. Colten, for being here this morning. I am delighted to have been able to read your testimony and to hear from you this morning.

For many members of this committee, and particularly for this member, sometimes it felt like it was a Big Ten game going on out there. And your alumni from each side are calling up and cheering and rooting for one side or the other, and they are all saying that Mr. Moore was an unfair referee and we had to get somebody else out there.

And so, you know, I am happy, delighted, because, you know, here were the veterans and here were the hospitals, who are very necessary. Both of you are so necessary to their care. People need

to understand that independent of your own self-interest as institutions, you benefit the veterans, the men and the women that go to the hospital.

Sometimes I felt like not saying anything myself since I didn't feel that objective since my dad goes to Lakeside, and I said, maybe something I said might go wrong here. What about when the West Side folks find out my dad goes to Lakeside? You know, it gets real tricky for all of us, and was extremely difficult, I know, for Mr. Moore and for Joan Cummings and for others involved in this process. And I kept saying to myself that I knew that this is exactly what was going to happen.

I said to myself—number one, I thought, doctors. In my view, who is a doctor? Somebody that I go to to get advice. I mean, I don't go into an office as a Congressman to go and argue the partisan debate with him. I go so that he can tell me how to get better.

Then I thought, deans. And since now I have been graduated for 25 years and I am not a university student, when I was an university student, I don't know if I held deans in that high regard. But 25 years later, as someone who is about to have his daughter go to the university, obviously I have a whole different take.

So between dean and doctors, I said—and the university, prestigious institution, University of Illinois, Northwestern, I said, I think they can figure this out, which was exactly my conversation with Mr. Moore when we sat down. I said, you know, I think they are going to figure it out in the end.

And I want to commend you and congratulate you. Let us know, because I think Dr. Moss, your point is well taken. It is going to be about resources, about how we nationally apply those resources, those dollars. And they are shifting.

And you are going to be—both of your institutions, I think, are going to be instrumental, fundamental, in relaying that information to the VA and being a source, an academic source, a credible, objective academic source, so that we can go and make those arguments when people want to say that all the veterans are going to Florida and Arizona and Southern California, and so you can do without this because we are going to shift those; that you can come back and supply that kind of coordinated message, not a message from the U of I and another one from Northwestern, but a coordinated message for our veterans.

Because in the end, it is more than your institutions. I know that. In the end, it is about men and women that your doctors and your physicians and your medical experts serve, that I know you do everything possible to serve them well.

So where those resources are at and, you know, some of these waiting periods and some of these problems, you know, are they independent of this consolidation? Because we have a consolidation that is occurring, and then people blame everything on the consolidation without looking at other objective factors, such as what is the Congress doing in terms of allocating resources.

So, you know, if consolidation came about at a time of many resources, you would probably have a much happier consolidation. But were it to occur, and I don't want people to get blamed wrongfully for things that went wrong. I want—because otherwise you don't get a solution. All you get is scapegoating of the process.

So I thank you so much for being here. You know, in the beginning there was so much confusion, so much bickering and fighting and turmoil—at least that is the way I remember it—that I am happy that you are here, happy that you are working coordinated, which I knew was going to happen because, you know, you serve the State of Illinois well, you serve the City of Chicago well.

I know what kinds of institutions you represent and I know what kind of men and women you represent. So thank you so much for being here.

Dr. COLTEN. Thank you, sir. We are actually rooting for Chicago VA now, not for single institutions in the Big Ten.

Dr. MOSS. Let's hope for better luck in the future on our football teams.

Mr. LAHOOD. Okay. Thank you both very much.

We are going to take a 5-minute recess and then the next panel will come forward. Thank you both for being here.

[Recess.]

Mr. LAHOOD. We are going to reconvene now, and I ask all of you to take your seats for our final panel.

Our final panel includes Dr. Joan Cummings, Network Director of Veterans' Integrated Services Network 12, Department of Veterans Affairs; Mr. Joseph Moore, Director of VA Chicago Health Care Systems, Department of Veterans Affairs; and Dr. Christopher Terrence, Chairman, Integration Coordinating Committee, VA Chicago Health Care System, Department of Veterans Affairs.

We are grateful to all of you for being here, and ask that each of you take up to 5 minutes to make whatever statement you would like. Your entire statement will become a part of the record. And then we will ask questions.

Whoever would like to go first.

STATEMENT OF JOAN E. CUMMINGS, M.D., NETWORK DIRECTOR, VETERANS INTEGRATED SERVICE NETWORK 12, DEPARTMENT OF VETERANS AFFAIRS; JOSEPH L. MOORE, DIRECTOR, VA CHICAGO HEALTH CARE SYSTEM, DEPARTMENT OF VETERANS AFFAIRS; AND CHRISTOPHER F. TERRENCE, M.D., CHAIRMAN, INTEGRATION COORDINATING COMMITTEE, VA CHICAGO HEALTH CARE SYSTEM, DEPARTMENT OF VETERANS AFFAIRS

STATEMENT OF JOAN E. CUMMINGS, M.D.

Dr. CUMMINGS. Thank you, Chairman LaHood, Congressman Evans, Congressman Gutierrez, and Congressman Davis, I would like to thank you all for this opportunity to discuss the integration of VA Chicago Health Care System at this field hearing.

I would like to state that the Lakeside/West Side integration is actually one element of a larger network strategy that is aimed at accomplishing five principal goals, and I want to just briefly discuss those and their relevance.

These goals are applicable to many initiatives across the country, not just in our network. And one is the reduction of costs. And in this VISN, we need to reduce our annual expenditures over the fiscal years 1997, 1998, and 1999 by approximately \$57 million.

With the new methodology for the allocation and procession of the funds for VA, this critical financial target will be achieved by our network, I think, in the framework of how we are doing things. We did manage to recoup the \$8 million in fiscal year 1997 with no reduction in service. We anticipate the \$40 million reduction in fiscal year 1998 will occur also without reduction in service to veterans, and the remainder will be accomplished in fiscal year 1999.

Cost of VA health care in Chicago is substantially higher than in the rest of the Nation, and the goal here, really, is not cost reduction for itself, but to bring VISN 12 into alignment with VA health care costs elsewhere.

A significant part of the problem in this regard is the overutilization of VA inpatient care in the Chicago area. And I want to stress, as we convert ourselves from a hospital system into a health care system, that the costs are going to be reduced by making our programs more efficient, not by diminishing the quality of the amount of care we provide to Chicago area veterans. In fact, we plan to provide better, more accessible care to a larger number of veterans.

We have reduced in this VISN over the last 2 years—1,600 acute care beds have been closed. This is with no waiting for admission, no denials of admission, and with occupancy rates across our VISN that still are not optimal. So the overutilization, historic inpatient care, is being accomplished without cuts to veteran service.

Our second goal is increasing our access. And again, this is not just our VISN goal. This is a nationwide goal for VA, to increase the accessibility of VA health care. I totally concur with Mr. Balcer's comments about travel times and waiting and trying to get from the south side of Chicago to a veterans medical center for care.

And we have a goal to increase our using population, those underserved Category As. When there are reductions in costs, those savings are being reallocated to increase access. We have been concerned for some time about veterans in the Austin area, where there is very poor access to VA. Hines has, with cooperation with the vets' center, opened a primary care clinic in Oak Park and collocated next door to the vets' center to increase that access.

We have established a clinic in Woodlawn to attempt to increase access for primary care to veterans on the south side, and recently VA Chicago, which is the parent of that clinic, has expanded the hours of the Woodlawn clinic, again to promote the access.

So as we create the efficiencies across our system, those savings will be put back into health care. We, as you may well know, have been approved to open a community-based clinic in Chicago Heights, another area within Cook County that has, really, very difficult travel to any of our medical centers and significant numbers of low income veterans.

So our major goal about redirecting some of these resources will be to increase the access of veterans to care and increase the numbers of veterans that can actually get to us for that care.

Third major goal for the integration is the modernization of VA health care. There is a need to modernize both the manner in which veterans' health care is provided in Chicago as well as to modernize our facilities. For example, in this VISN we have had significant expenditures into our infrastructure to be able to accom-

modate the computer age and be able to transfer information from site to site so that veterans' records and their health information is accessible wherever they receive care. And again, given the federal funding realities, this also needs to be accomplished within what budget we have.

We are changing from a hospital system, which we had been historically, into a health care system. And the infrastructure that we develop with our computer network will allow the outpatient care, which is going to be given hopefully in multiple areas across this VISN, to be effective and to assure that the veterans' records and medical information is available at each one of those outpatient care sites.

Our fourth goal is really the optimal utilization of VA capital assets. We have begun looking at elimination of unnecessary duplication or redundancy. We have consolidated some of our administrative services. For example, all of our contracting for this area is done as a single entity, which gives us volume buying for eight facilities as well as efficiencies in the contracting.

We have increased telemedicine usage to handle areas where scarce medical specialties aren't available. This is one of the areas that VA Chicago is an asset for us in terms of supporting some of the rural health care in our VISN, such as at Iron Mountain, MI, where specialists are not as available, and they will actually get support from VA Chicago without those clinicians and specialists having to travel by the use of telemedicine.

The fifth goal is to really insure consistently high quality care, and many of the performance measures that we are looking at and collecting data across the VISN are to say that as we undergo these changes, that we give consistently high quality care throughout the network.

This is being measured by a series of measures, both of our performance measures and in looking at our outcomes, but also by veterans' measures. And I agree with many of the previous panelists that the people we serve need to be included in that.

We have a Management Assistance Council that had been referred to earlier coming up in November, and I will be giving them information from our veteran satisfaction survey which we just received, and I am very proud to tell you that this VISN has improved satisfaction in every measure on that satisfaction survey with the exception of family education, which we are going to improve this year.

This includes access so that the veterans who respond to our satisfaction survey are indicating that the changes we are making are improving the care in areas of access, and courtesy which is rated one of the five highest in the Nation by the veterans in terms of looking across the VISNs at the satisfaction survey.

These are the kinds of measures that we need to continue to do. I don't have results of the outpatient survey, but we hope to get that in November. It is the kind of information we will be sharing with all the facilities and sites of care to see that they know exactly how the veterans that they serve are perceiving the care that they receive.

I would also at this point like to take the opportunity to all here, both the committee and to all in the audience, to reaffirm my belief

that both the Lakeside and West Side divisions are essential, and that I and the department have no plans to close either division.

However, if we are going to achieve the five goals that I just discussed—reduce costs, increase access, modernize our health care system, and optimally use our VA capital resource while insuring high quality care—there is a need to change how these facilities provide the care and what specific services they provide.

I think one of the biggest changes that does cause concern is this move to outpatient care, as we set up outpatient clinics and community-based primary care sites with these two additions serving as the nub of their tertiary care.

In terms of an update on the integration, the Integration Coordinating Committee met on October 1, 1997. The final reports were given. The committee felt that their work has been completed. Dr. Terrence, the chair of the committee, who has been absolutely invaluable to us in this VISN, thanked all of the members for their work and announced the final meeting of the group, as it had completed its task.

The Stakeholders Advisory Group met yesterday, on October 15, and again, the members were thanked for their work. That advisory group as a separate group is being disbanded. Most of those individuals are on either the Management Assistance Council or the Veterans' Advisory Council that I have.

We will be reviewing the membership of that group to assure that those individuals on that Stakeholders Advisory Group are on one of those other groups to continue their input in the meetings we have, both at the facilities and separate meetings at the VISN office.

Our Management Assistance Council is quite large. It meets twice a year. Because of that, we have had subcouncils of that set up so there are quarterly subcouncils with the Veterans' Service Organizations and the congressional delegation, both in Illinois and then we repeat them in Wisconsin to assure that folks have access to them, that are held in addition to the Management Assistance Council.

And we will assure that those individuals were put on those groups in place to continue that input, because I totally concur with many of the remarks that the input of the stakeholders is nothing but beneficial.

It has improved the quality of the decision-making, I believe, of the integration coordinating committee and through the Veterans' Advisory Council and the MAC that I get, and I think improved the functioning of the VISN as a whole.

That would conclude my remarks, and I would be happy for any questions, Mr. Chairman.

[The prepared statement of Dr. Cummings appears on p. 45.]

Mr. LAHOOD. Thank you very much.

STATEMENT OF JOSEPH L. MOORE

Mr. MOORE. Thank you. Mr. Chairman, members of the subcommittee, it is very nice to follow your boss. Then you can cut out most of your testimony.

I want to say that when we embarked on this integration process, we chose Webster's words on faith: "A firm belief in something

for which there is no proof." When we embarked upon this journey, my faith in the veterans, in the VA, and in the merits of the task before us assured me that we would accomplish this with success.

Well, I point out that many naysayers said it won't work. Well, I am here before you today with my faith intact, and to tell you that it will.

And I would like to show off some of VA Chicago. I have my two associate directors, my two chiefs of staff, and my 16 department heads of VA Chicago. Please stand.

Mr. LAHOOD. Welcome to you all. Great to have you all here.

Welcome, Mr. Moore.

Mr. MOORE. I think that is a diverse group. No matter what anyone says, I want you to know that they were chosen from equal measure. There are eight from VA Lakeside division and there are eight from VA West Side division. Thank you.

I am not sure how we could convince the world more that we are here to do the right thing. But I think, in closing with my testimony, and I won't say all of these things because my boss has said it so eloquently, I saw a movie and it said, when there is a sparrow that is hurt in Central Park, I feel it. And so it is about VA Chicago.

I am pleased to be here, and I will answer any of your questions. And you said my testimony in the whole will be in the record. Thank you.

[The prepared statement of Mr. Moore appears on p. 57.]

Mr. LAHOOD. It will. Thank you, Mr. Moore.

Dr. Terrence, welcome.

STATEMENT OF CHRISTOPHER F. TERRENCE, M.D.

Dr. TERRENCE. Mr. Chairman, other speakers and guests, good morning. Thank you for this opportunity to discuss the Integration Coordinating Committee of the VA Chicago Health Care System.

I have one advantage. I am an out-of-towner. I am not from Illinois. I am the chief of staff at the VA New Jersey. I was charged by Dr. Kizer on October 1996 to be the chair of the Integration Coordinating Committee of the VA Chicago Health Care System.

In his letter of appointment, Dr. Kizer stressed that there were "no preset determinations. The process should be open and data driven, and that all reports and recommendations reviewed by the VISN director and subsequent review at the Under Secretary of Health level."

One of the guiding principles that the Integration Coordinating Committee shared early in the process was the need for maximum involvement of the affiliates, the stakeholders, employees, and other interested individuals.

As of today, over 300 individuals in the VA Chicago health system have been involved in the ICC process as members of either committees of the ICC or subcommittees or the stakeholders group.

At the first meeting of the Integration Coordinating Committee, it was decided that we would proceed forming chartered work groups with the support of the medical center director. The groups were given service-specific charges to develop a health system that would maintain the quality or enhance the overall service to the

veteran while minimizing the costs inherent in operating two tertiary care hospitals.

The committee decided to start with the services that were relatively noncontroversial in order to prove that the process was valid and could be accomplished in the context of the VA Chicago Health System. When the group completed its proposal, the proposal was submitted to the Integration Coordinating Committee for its review and subsequent recommendation to the medical center director.

The proposal was reviewed also by the Stakeholder Advisory Group, by the chairman of the various work groups. The recommendations from the Stakeholders Advisory Group were brought forward to the ICC in order to provide maximal input into the deliberations of the ICC.

The various work groups were chaired by various service chiefs, but in some instances, such as surgery, medicine, and psychiatry, the groups were chaired by members of the University of Illinois Medicine faculty or representatives of the Northwestern University Medical School faculty.

In order to keep the staff up to date at the two divisions, up to date on the process, we used a number of various means. The first was using town hall meetings. We held four town hall meetings at the various sites to discuss the work of the integration coordinating committee.

There has also been regular updates of the ICC in the Chicago Health Care System newsletter and also the minutes of the—all meetings of the ICC were put on the centralized hospital computer, which meant that all the employees could look them up in the computer and see what the minutes contained.

By October 1 of 1997, all the work groups have presented their recommendations to the ICC. Most of the recommendations have been forwarded to the medical center director with little changes. A few have been referred back to the services work groups for slight modifications.

The ICC has approved the goals and mission statement of the VA Chicago Health Care System. In addition, the committee has recommended the replacement of angiography equipment at West Side and the replacement of cardiac cath equipment at the Lakeside division.

The committee has recommended the integration of the ambulatory care services. The committee has built up a track record of accomplishment which has allowed us to deal with the thorny issues of affiliation interests and placement of bed services.

In order to facility the process among the bed service work chiefs, Mr. Moore and I met with all the bed service chiefs in the beginning of this fiscal year to discuss with them the ongoing progress.

In summary, I believe that the ICC of the VA Chicago Health Care System has worked very diligently in setting up a process and framework for integration of two tertiary care hospitals. That committee would never have been successful without the support of the four medical school deans who were members, the union representatives who contributed greatly, the chair of the stakeholders group, and other veterans service organizations.

Thank you for this opportunity to present this brief overview of the ICC. Thank you, Mr. Chairman.

[The prepared statement of Dr. Terrence appears on p. 63.]

Mr. LAHOOD. Thank you. Congressman Evans.

Mr. EVANS. Thank you, Mr. Chairman.

Dr. Cummings, the network facility development plan that you participated in as a director at Hines Hospital and testified before one of our subcommittees in 1994 had a different plan for integration of services. The plan included all of the Chicago-area facilities, not just Lakeside and West Side. The recommendations were quite different from those made by the ICC.

So I would like to ask you, do you still believe that the network facility development plan still offers a guide post for VISN planning efforts, and if not, explain the reasons for your different view.

Dr. CUMMINGS. Yes, Congressman Evans. That plan that was done as a pilot was the first time it was attempted to have more than one facility develop a development plan. Prior to that, the VA had always had individual facilities develop this development plan in a vacuum from what was around them.

And as a pilot, they attempted to do this for the four facilities in the district. That plan actually was never finished, and the plan was never accepted by either the district or the regional director or Central Office.

The recommendations and the workbooks we have on that that we did—and I was actually the chair of the district then—as facilities working together, I believe there is only one of the recommendations that was developed and accepted by the VA. So that, really, still was the report of the consultants that were hired to develop that plan.

That is not to say that that information may not be useful to us in the future, but it was never adopted as a plan for us to go forward. And as a matter of fact, prior to the reorganization of VA, there was an overt motion at our district council that stated that we had not accepted it, and that we would take that information and use that as was needed in any future planning.

It then subsequently became overtaken by the reorganization into VISNs, and we have not really used any of the recommendations in our planning. Some of the data about the square footage and some of the others have been used in our capital asset planning. But we then began a planning of a much wider area.

Mr. EVANS. You know, I know a lot of people say that the way the VA ought to be going is to more outpatient clinics. Can you tell us what the process is for determining where outpatient clinics are located?

Dr. CUMMINGS. Yes. I am very pleased with this outcome; it is how we picked the Chicago Heights and the Woodlawn—what we have done is we have used the existing data. There is a veterans survey, and using that and the census, the U.S. Census, you actually can identify areas that have high Category A populations so that we can better provide for underserved areas.

And we have used across the VISN that data technique. It identified the Austin area I told you, where less than 40 percent of the Category A veterans use any VA facilities, and yet we know the economics in Austin indicate it should be higher.

With that data, we identified the Woodlawn area, Chicago Heights. LaSalle/Peru is one that we are working on, which also has very similar demographics. So we have used that and focused on areas where there is underserved need.

And in addition, the City of Chicago—and I don't remember exactly where it came from, but they developed some years ago a transportation grid when they were looking at a health care system.

We have that, and we have superimposed that over some of these demographics to look at access routes. And it has given us the information such as the fact that, really, from Chicago Heights you can't get to any of our VA hospitals without a car.

So we have used demographics like that to try and locate the community-based clinics.

Mr. EVANS. The SEIU, the Service Employees International Union, says that industry-wide an employee cleans an average space of about 1,500 square feet, but that right now at the hospitals they have gone through a major reduction in cleaning employees. They used to have 286 people cleaning ten buildings. That is down to 179 employees, so that one person is now responsible for cleaning 33,000 square feet.

Have you looked at those standards? If you can't tell me today, could you submit that to us for the record? I think it is one indication we can save money by downsizing, but if the quality diminishes, that is a real concern of ours.

And also, we would be interested in your response to the allegations made that cuts in administrative staff and LPNs and nurses' aides are impacting waiting periods for patients within the clinic or within the hospital already. Do you have any thoughts on these issues?

Dr. CUMMINGS. Well, yes. My general data—I have general data. Our length of stay at both Lakeside and West Side has continued to drop, increasing that they are accomplishing more in less time, so that we have dropped our bed days of care across the system.

And Lakeside and West Side have both done this in similar kinds of proportion, almost by 50 percent over the last year, so that the length of stays at each of the facilities—and while I believe there can still be improvements, the efficiencies in terms of getting what needs to be done during an inpatient stay does not seem to have been adversely impacted.

The access portion of the veterans survey information also indicates to us that the veterans we serve seem to have increased access. We do routinely monitor waiting times, Congressman Evans.

I can't tell you that I remember specifically the waiting times for clinics, but it certainly is something that we can send to you afterwards because we look at waiting times for all of our clinics and entry into specialty services. And that is one of our performance measures. And I would be happy to send that.

Mr. EVANS. If you could submit those, Mr. Chairman, I would like that information made part of the record of the hearing.

Mr. LAHOOD. Without objection.

Dr. CUMMINGS. I would be happy to do that.

(Subsequently, the Department of Veterans Affairs submitted the following information):

Appointment waiting times

VACHCS is on target

Waiting time for primary care is 24 hours or same day since the primary care FIRMs allow walk-in assessment of patients assigned to the FIRMs.

Waiting times for specialty clinics were within 30 days:

<u>Clinic</u>	<u>Appointment waiting time, calendar days</u>
Cardiology	6
Ophthalmology	22
Hematology/oncology	7
Orthopedic	5
Diabetes/endocrinology	1
GU	30
GYN/women veterans	19

Although we currently are within national customer service standards and VISN 12 targets, we continue to review and monitor appointment waiting times for any necessary adjustments. West Side has increased clinic times and physician hours.

We plan to use the algorithm developed by the VISN 12 medical task force to review the average waiting times to the next new appointment and when necessary re-engineer practices in specialty clinics.

Square Footage Assignment

This is to inform you that the Chicago Health Care System is comprised of approximately 1.9 million square feet of floor space. Environmental Management Service is responsible for maintaining approximately 1.3 million square feet of this space. The service is authorized 123 housekeeping aids and currently have 105 on board. Each employee is responsible for cleaning/maintaining approximately 12-13 thousand square feet of floor space which is in line with the national cleaning standards (10- 12 thousand square feet per employee).

Mr. EVANS. Thank you, Mr. Chairman.

Mr. LAHOOD. Congressman Gutierrez.

Mr. GUTIERREZ. Well, first of all, Dr. Cummings, let me thank you for making the special effort of being here today. I know you were going to be in Washington, DC, but didn't want to miss this hearing. So I appreciate the effort that you have made to be here and to listen to the veterans of Chicago.

Dr. Cummings, under the Veterans' Equitable Resource Allocation, VERA, funding structure, our local VA network is scheduled, as you testified, to lose \$57 million during the next 3 fiscal years. I am sure that the integration process has taken into account these reductions and savings needed to recoup just the \$57 million.

I want to know, however, how much savings the integration of West Side/Lakeside will incur for the next 3 fiscal years.

Dr. CUMMINGS. I can't—the third fiscal year I can't give. I don't know that. But we do know if we restrict, and I think it is important to remember that we have to look at not just the integration but what else are we doing.

For example, one of the major savings in our VISN is a single laboratory plan for testing of blood samples across the VISN, and that has accounted for about \$2 million in savings this last fiscal year and hopefully more.

So a lot of what we are doing, the reducing of the bed days of care and closure of acute beds that result in cost savings, aren't related to the integration. Those are VISN-wide goals.

If we were to look at only the integration, in the last fiscal year that we are just finishing, estimated that attributable to integration itself is probably \$2 million. And that has to do with the fact that many of the areas, as we begin to combine services and do things more effectively, that does decrease your cost. And we expect that a similar figure, our estimate for this coming fiscal year is in the range of \$3 million.

I must admit that it is very difficult for me to get beyond that to predict the further years since it really depends on what the work—you know, the continued single services, what plans they make. But we would expect probably \$3 million in this year.

Mr. GUTIERREZ. And you also stated that in VISN 12, by the year 2002 you want to see veterans care in Chicago expanded to 28,000 new users. This, of course, would occur as outpatient care is expanded throughout the region, and you have talked about Woodlawn and the West Side and having more settings for people to come and receive care.

My concern is that under the new funding allocations that we just talked about, 57 million fewer dollars over the next 3 years, that Chicago will lose resources, obviously, and that the savings that you make up from the integration of duplicative service and reduction of waste will first have to be devoted to remedying the new mandated short falls.

Is it realistic under this scenario, with resources diminishing and integration fading, first having to pay the short fall, the 57 million bucks, that that can really be expanded, fewer resources, integration, you have got to put the money—because you have \$57 million. You are expanding. How do you do that?

Dr. CUMMINGS. I believe it can be done. And let me use our laboratory service plan as an example of that.

We ran in this VISN eight separate hospital laboratories that, by and large, did 80 percent of the tests that commonly hospitals did. We no longer do that. As many of you know, laboratory testing is largely automated on huge machines. We analyzed the data and the work load and found out that, really, two of our facilities, the two large ones, Milwaukee and Hines, could handle the vast bulk of our laboratory testing, and that we didn't have to run eight separate full-service labs.

We looked at some other private sector experiences. The Mayo Clinic hasn't had a lab in its building for years. In Indiana, the same circumstance. That is estimated to save us about \$7 million a year just in its initial phase of implementation, and we think we can expand that kind of consolidation of workload to include some merged testing and other various types of testing.

It has also enhanced our quality in that some tests, things like thyroid function and others, where the volume at any one of the facilities was such that they only ran the test, say, once or twice a week, we now can run them daily.

So I believe that we need to reengineer how we give the care—one of the work groups in the integration has proposed that there only be one kitchen to serve those two facilities. That is—a lot of the world does that, and there is no reason not to do that. That will save money.

We have looked at other kinds of mechanisms. I have mentioned our consolidated contracting. So I believe that as we reengineer how we do things and we do things as eight regional entities versus eight separate facilities, there are savings to be made to reinvest in outpatient care.

The other major area that I am very pleased with, and unlike some of the other aspects of VERA, it is one where this VISN does well and, really, with the help of your committee as well as Congress itself, is our medical cost recovery.

We now are able to retain third party insurance payments. This VISN is actually one of the VISNs in the country that is a leader in collecting insurance funding. We appear to have at least a slightly higher rate of individuals having insurance, and we have done well with collections. We think we can increase those collections.

That also is another revenue source that we can use to increase our access into the outpatient clinic areas. So I believe it is possible. I think that it will require more reengineering and more looking at what we are doing collectively across the VISN.

We do have the Chicago Heights clinic. We plan to open that, we would hope, as soon as we finish the leasing things over the next several months and get the space there. As I said, we have already expanded the Woodlawn clinic. We expect to open a clinic in La-Salle/Peru and one in Union Grove, which will probably serve, also, some of the veterans in northern Illinois this coming year.

So I think it is possible.

Mr. GUTIERREZ. Mr. Chairman, I would just like to take a moment to recognize Bob White from the Paralyzed Veterans of America, and ask that the record be kept open in order for the Paralyzed

Veterans of America's testimony to be included in the hearing record today.

Mr. LAHOOD. Welcome, Mr. White, and the record will be held open.

Mr. GUTIERREZ. Thank you so much.

Mr. LAHOOD. Thank you for being here.

Mr. GUTIERREZ. And we will include—we will keep the record open until you can submit that. Thank you so much for being here, Mr. White.

Dr. Cummings, there is a—the ICC and the SAG group got together and met and ended its formal function. Given some of the things that we have heard here today, and given that all of the process has not been completed, how do we end the process at one end in terms of the—I mean, one of the—and Chairman LaHood, you weren't around for all the beginning of this, but if you had, you would understand more keenly, given the lack of communication at the beginning, which I think we can say we didn't know how to do it any better; it wasn't that we didn't want to do it this way, everybody is delighted with what we got today—and given that we haven't ended it yet, shouldn't we keep a safeguard in there since we started Woodlawn, we started with none, we integrated one, and now everybody has come here to talk about how they are all talking and working together, and then we are going to end without one.

So how do we get the stakeholders in the end process?

Dr. CUMMINGS. Yes, Congressman Gutierrez. As a matter of fact, we had a meeting yesterday with the veterans service organizations and some of the congressional staffers. I believe that the input is essential.

Many of the members of that stakeholders council are either on my Veterans' Advisory Council or on the MAC, and as I mentioned in my testimony just briefly, I am going to take that group and make sure that all of them are on one of those groups.

I think it is important to put them on that because that is probably where the communication occurs. One of the issues that has come up in the integration is, we talk about things that are VISN initiatives, and yet since they are happening at West Side and Lakeside divisions, as they happen everywhere, somehow they get confused with the integration.

Yesterday at the meeting that I had with the service organizations, and we are going to do this again with my MAC, we took—as you know, the VA is required to do these business plans and our strategic plans. Ours is due the end of October, beginning of November.

I took all of the initiatives for that plan and gave them out to our stakeholders at those two meetings, and we will do it at the MAC, to solicit their input. And we discussed our initiatives—reducing the bed days of care, opening the community-based clinics.

And I think that getting them in that group, they will have access to wider information and it will be more consistent because it will include things that impact Lakeside and West Side that don't have anything to do with the integration.

And I certainly agree with the testimony, and we will make sure that the groups who were on that stakeholders have access to those

meetings. And they meet quarterly with us here, and are on groups that can continue that input, because if there was anything that we could have done differently on this integration, it would have been start the stakeholders council before the newspapers reported about integration.

Mr. GUTIERREZ. So I am just—we can meet at another time. Obviously, because I think I know what is going to happen. I think we have got an excellent process going on, but I have pretty keen understanding about how a great process can fall apart at a very critical moment.

So I will talk to Congressman Danny Davis, because he and I are good—not that Congressman Lane Evans won't hear from the stakeholders, but we are—being such in the vicinity, being from Chicago and having been involved in this process. I don't want it to fall apart at this point.

So let's try to find ways where we can take the stakeholders who we have integrated into the process and keep them in the process at different levels and maybe have a little flexibility. We will talk about that some more later on.

And I look forward to having that opportunity to do that with you.

And I want to—I had a question. Somebody did raise a question, Mr. Chairman. They took me up on providing a question. And that question is to Dr. Cummings.

What is being done to avoid pushing veterans who need long-term care out of the system? And, in parentheses, in the interest of saving money?

We have learned of one Vietnam veteran who was discharged from North Chicago and had to fight for readmission, particularly after doctors in the private sector discovered he had cancer. Can we avoid this from recurring in the drive to reintegrate Lakeside and West Side?

It is not my question, but if you could answer it as best you can.

Dr. CUMMINGS. Obviously, I don't know the specifics—we could certainly try and investigate the particular incident.

But let me just speak about long-term care. West Side and Lakeside—and this is independent of the integration; West Side and Lakeside have no long-term care, and have not in the past. So it is not a piece of the integration.

We have long-term care sites at five of our VISN facilities. The whole issue of long-term care, particularly nursing home care, in the VA is one that—actually, there is a federal advisory committee the VA has chartered, and I am on it, to look at it, because as you are aware, in eligibility reform, there was no change in nursing home eligibility.

We have not changed our numbers of long-term care beds in this VISN. We have actually increased them slightly in terms of the domiciliary in North Chicago.

But the issue of the future needs for long-term care is one that I think needs a lot of looking at and a lot of input. There has been concern across the country. We are looking at ways to continue as efficiently as possible the current long-term care we do, but also to look at the future.

For example—of all nursing home care that veterans use, VA provides approximately 15 percent of that nursing home care. That figure has been stable for, I believe, 10 or 15 years.

So the VA is a significant player in nursing home care, as you are obviously aware. Except for VA, the major payers of nursing home care are the individual and public aid.

So we are a significant player. But there has been no change in that number that we can see. I think that this is a challenge that VA needs to look at, nationally and I think it needs a national policy.

The advisory committee is being asked to present to Dr. Kizer and VA recommendations on what should we do with long-term care. And I think we have had one meeting, and I think we are due for another meeting in November to look at that.

It has a lot of experts in geriatrics and long-term care outside the VA to give advice on this. But I don't think the answer is clear to us on what is the VA's role and how much of a role in the long-term care that individuals need.

Now, the other long-term care that is not nursing home care, I am very proud of. The VISN has got several task groups looking at expanding home care, making sure that we cover areas—certainly the major urban areas first, and then address how we provide home care in the rural areas.

And we have a long-term care task force that is looking at both that and at adult day care. So I think in those areas of long-term care that come under eligibility reform, we have groups from across the VISN with representatives to look at that, and to make sure that we give access to those kinds of care to as many veterans as we can.

Mr. GUTIERREZ. Well, I would like to end by saying to Dr. Cummings and Mr. Moore and Dr. Terrence, thank you so much for your leadership in continuing the ICC and keeping everybody together and working to get everybody's recommendations together.

And I would say, Dr. Cummings, congratulations. This is a far cry from—we are not past the goal line, but this is a far cry from when we were huddled back in my office. I don't know if you remember that cold day.

I had an advisory committee meeting. I usually have about 15 veterans, 15 to 20 veterans, at my advisory, and my office was full, if you remember. And Dr. Cummings was sitting there among about maybe 75 veterans.

I am happy to say I keep in touch with all of them. Once they came, they continue to keep coming back. So it was very positive for me in terms of gathering information. So we are a far cry from there.

And I still want to say—I want to leave one last thing for the record, because I think that while Dr. Cummings kind of took some of the slings and the arrows in the beginning because she started out this process and she was in charge of the VISN, much of the focus shifted quickly to Mr. Moore and his new ascendance to coordinating both facilities.

And I want to say that I am delighted and excited about your presence here today and the work that you have been able to do, and I want to tell you, sometimes in the work with the public and

in developing public policy and in working, which you have dedicated your life to the public—

Mr. MOORE. Your job is safe right now.

Mr. GUTIERREZ (continuing). It happens. It happens. So thank you very much, Mr. Moore, because I know how personally difficult it must have been at times for you. Thank you for being so steadfast and earnest and dedicated to your work. I know it could not have been easy.

Thank you all very much for your testimony.

Mr. LAHOOD. Mr. Evans, any further questions?

Thanks so much for this panel and for your testimony and your expertise. And I want to also thank, again, Congressman Gutierrez for his efforts in arranging this hearing, the Chicago Park District for the availability of this facility, all the interested citizens who attended, and the interest of our members who testified and were willing to answer questions.

And as was stated earlier, the record will be kept open and be available for anyone who would like to include anything else.

And we are adjourned. Thank you all.

[Whereupon, at 11:05 a.m., the subcommittee was adjourned.]

A P P E N D I X

STATEMENT OF

GERALD S. MOSS, MD

DEAN

COLLEGE OF MEDICINE

UNIVERSITY OF ILLINOIS AT CHICAGO

**COMMITTEE ON VETERANS' AFFAIRS
SUBCOMMITTEE ON OVERSIGHT AND INVESTIGATIONS
UNITED STATES HOUSE OF REPRESENTATIVES**

OCTOBER 16, 1997

CHICAGO, ILLINOIS

Good morning, Mr. Chairman and distinguished members of the Veterans' Affairs Subcommittee on Oversight and Investigations. My name is Gerald Moss. I am a Professor of Surgery and Dean of the College of Medicine of the University of Illinois at Chicago. I appreciate the opportunity to appear before you this morning and to update you on developments in the relationship of the VA Chicago Healthcare System with the UIC College of Medicine.

First, I want to express my thanks and the appreciation of the University to Mr. Gutierrez, Mr. Davis, Mr. Evans and Senators Moseley-Braun and Durbin and to former Member of Congress Cardiss Collins for their outstanding leadership on this issue. I am convinced that their efforts have brought about many constructive developments in this evolving relationship and have been of enormous value in meeting our joint responsibilities to provide care for veterans that is truly second to none. I am particularly proud to note that the University of Illinois and Northwestern University were the first two universities to establish a direct and formal relationship with the VA health care system more than a half-century ago.

All of us in health care are being challenged by enormous changes in the financing and delivery of health care, and many of those same changes are affecting the VA. We fully recognize that the VA must adapt and adjust to those new operational and fiscal realities, and I want to assure you that UIC is committed to working with the VA to make those changes in a way that benefits veterans and optimizes the educational environment of both institutions.

As you know, we have been concerned about proposed changes in the VA system here in Chicago. We became quite alarmed in May 1996 when a memorandum was issued by the Great Lakes Veterans Integrated Service Network announcing the intention to consolidate inpatient services in the city of Chicago at one of the two existing hospitals, and there were strong indications that the inpatient services to be closed would be those at Westside. The prospect of losing this critically important relationship which had worked for the benefit of both institutions for so many years was one we saw as warranting our undivided attention. In my view, the rationale for this action was not clear, the decision was not driven by hard data, and the process was arbitrary and indifferent to the concerns of the University and of the community.

As a result of the involvement of the Illinois Congressional delegation and of the then-Secretary of the Department of Veterans Affairs, a process was subsequently established which has addressed many of our concerns. Although there were several false starts, I am pleased to report to you today that the Dean of the Northwestern University School of Medicine, Dr. Harvey Colten, and I have worked out an agreement that we are convinced will serve the VA, its patients, and our students well. Specifically, we have agreed that we will propose to the Director of VA Chicago, Mr. Joseph Moore, a joint Dean's Committee made up of members from both medical schools and both divisions of VA Chicago to replace the two existing Dean's Committees. We believe that this joint committee will assist VA Chicago to realize operational efficiencies, to preserve the high quality health care that our veterans deserve, and to maintain the superb educational and research environment afforded by the VA system.

This is clearly a work in progress, but there may be lessons in the Chicago experience that will be useful in other areas of the country as the VA strives to consolidate its facilities to reduce duplication and overlapping efforts. I believe that a rational process for such consolidations would involve the following steps:

1. The VISN director would identify those areas in which duplication of effort seemed likely and where geography might permit service consolidation.
2. The stakeholders in existing facilities would be convened and a clear articulation of the problem would be presented.
3. A mutually agreeable process would be constructed with appropriate representation from all affected parties.
4. Appropriate consultation from a neutral third party, preferably expert in health system consolidations or mergers, would be sought.
5. All the data necessary to make a fair, balanced, and equitable decision with high face validity would be assembled.
6. Adequate time for these deliberations would be provided.
7. Appropriate opportunities for public explanation and input is essential.
8. A durable oversight mechanism to ensure that all parties are treated fairly would be put in place. No merger of complex institutions can be accomplished in a short period of time and be expected to function exactly as its architects intended. Mid-course corrections will be inevitable.

I would respectfully recommend that this Committee consider these criteria carefully, which may well serve to guide VA mergers or consolidations across the United States.

UIC has been working with VISN 12 to establish a system to evaluate the health care needs of the veterans population of this area and to advise it on how VA might best meet those needs in the Great Lakes Network. I believe that this is a very tangible example of the kind of resource that academic institutions bring to the VA that have made these partnerships so mutually beneficial.

I also want to emphasize a recommendation made by Dr. Jordan Cohen, Executive Director of the Association of American Medical Colleges, in his testimony before this committee on July 24, 1997: that the VA incorporate an assessment made by deans of affiliated medical schools in the annual evaluation of Network Directors.

There is one other area of concern to me and many of my fellow deans. The Veterans Equitable Resource Allocation (VERA) is shifting money from VA systems in the northern tier of states to those in the southern tiers. We are concerned that the methodology employed does not take into account the health status of those veterans in the northern states, and it does not recognize that the majority of training programs (with their attendant higher costs) are located in these states. I hope that the Committee will objectively evaluate the effects of this new resource allocation system, and make corrections if they are found to be necessary. I also hope that there will be continued oversight of the VACHCS integration process and in this regard, I recommend continued existence of the Stake Holders Advisory Group.

Mr. Chairman, I am grateful for your interest and leadership in this extremely important issue. The College of Medicine of the University of Illinois at Chicago and I, as a veteran myself, are extremely proud of the relationship we have with our affiliated VA Medical Center.

I welcome the opportunity to answer any questions you may have.

Northwestern University Medical School



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Testimony Before The Oversight and Investigative Subcommittee Of the Veterans Affairs Committee

United States House of Representatives

Good morning. I am delighted to be here, and appreciate the opportunity to testify before this committee on matters of importance to Chicago area veterans and the providers and institutions that serve them.

I am particularly pleased to be able to report to you that efforts to integrate two formerly separate institutions – the Veterans Affairs West Side and Lakeside facilities – into a single VA Chicago Healthcare System are succeeding. This integration is producing a rational alignment of services between these two institutions and the rest of the VA Great Lakes Health Care System. Better quality health care for veterans and improved efficiency are the expected outcomes of this integration.

The two affected medical schools are collaborating effectively in the integration process. As one example, you will be glad to know that you will hear substantially the same message from Dean Moss and me this morning.

The public-private partnership between the VA and Northwestern University, and the public-public partnership between the VA and the University of Illinois, have benefited the veterans who seek health care at these institutions by ensuring the highest quality medical personnel are available. As academic medical centers, both the University of Illinois and Northwestern University enjoy what might be described as a sunshine culture; an environment where data are openly available to be analyzed and information is used to improve teaching, research and patient care. We have capitalized on this culture in the integration process, and we believe that our institutions and the veterans they serve will benefit from the stronger VA Chicago Health Care System that we are helping to create.

Let me begin with a bit of history on the integration and background on Northwestern University's relationship with VA Lakeside. In June of 1996, the Department of Veterans Affairs announced the intent to integrate VA Lakeside and VA West Side under a common management structure, the VA Chicago Healthcare System. From its inception, the vision for the VA Chicago Health Care System has been to be the best in the nation – providing the best care as efficiently as possible. The leadership of the VA Chicago Healthcare System and the affiliated academic institutions share this vision and are committed to achieving it. We have worked diligently with members of Congress, the Department of Veterans Affairs, Chicago area medical schools, veterans, and other stakeholders to successfully integrate the operations of the two hospitals. This morning, I will briefly report to you on our progress.

The VA and its academic partners have long recognized the mutual benefits of collaboration. Northwestern University has been affiliated with VA Lakeside since the doors were opened in 1954. In the case of the previous Northwestern University-VA Lakeside affiliation, over 21,000 veterans received health care services in 1995. The Lakeside Division of the VA Chicago Health Care System provides salary support to 148 Northwestern University faculty; an additional 263 Northwestern University faculty provide services without compensation to veterans at the Lakeside Division.

Finally, 545 medical residents each year provide patient care and acquire clinical skills in the Lakeside Division.

The relationship between the University of Illinois and the West Side Division of the VA Chicago Health Care System has produced comparable benefits for both partners and, most importantly, for the veterans they serve.

The integration process has progressed remarkably smoothly under the leadership of Joseph L. Moore, Director of the VA Chicago Health Care System.

An Integration Coordinating Committee, which includes the Deans of all Chicago medical schools with a VA affiliation, oversees and coordinates the service specific integration work groups. Thirty-two work groups, with representation from both schools of medicine, are making recommendations concerning the integration of their respective services.

A Stakeholders Advisory Group provides constituent input to the Integration Coordinating Committee and the integration work groups.

Thirty-one of the 32 work groups have submitted reports to the Integration Coordinating Committee. What has been accomplished already is impressive. Sixteen services are now consolidated under a single service chief: audiology and speech pathology, chaplain, engineering, environmental management, information resource management, library, medical administration, nursing, nutrition and food, pharmacy, police and security, psychology, prosthetics and sensory aids, recreational therapy, social work, and voluntary. More single service chief appointments are likely during the next year.

This integration is one element of a larger VA Great Lakes Health Care System strategy aimed at accomplishing five goals: increased access, modernized VA healthcare, optimum utilization of VA capital assets, reduced costs, and high quality care. Because of the shared commitment to education, research and patient care shared among the VA Chicago Health Care System, the University of Illinois, and Northwestern University, we are advancing toward these goals.

Thank you for the opportunity to testify today, and your interest in veterans' health care in the Chicago area. I would be happy to answer any questions the Committee might have.

A handwritten signature in black ink, appearing to read "H. Colten". The signature is fluid and cursive, with a long horizontal stroke extending to the right.

Harvey R. Colten, MD
Dean, Northwestern University Medical School
Vice President for Health Affairs, Northwestern University

**STATEMENT OF
JOAN E. CUMMINGS, M.D.
NETWORK DIRECTOR
VETERANS INTEGRATED SERVICE NETWORK 12
HINES, ILLINOIS
October 16, 1997**

Mr. Chairman, other speakers and guests - Good morning and thank you for this opportunity to discuss the integration of the VA Chicago Health Care System (Lakeside/West Side Divisions).

I would like to state that the Lakeside/West Side VAMC integration is one element of a larger Network strategy aimed at accomplishing five principal goals. These goals are to:

1. **Reduce Costs:** Over the three fiscal years 1997, 1998 and 1999, VISN 12 needs to reduce its annual expenditures by \$57 million. According to the VERA methodology, this critical financial target will be achieved by reducing Network expenditures by \$8 million in FY '97, \$40 million in FY '98, and the remainder in FY '99. As you know, the cost of VA healthcare in Chicago is substantially higher than in most of the rest of the Nation. The goal here is simply to bring VISN 12 into better alignment with VA costs elsewhere. A significant part of the problem in this regard is the over-utilization of VA inpatient care in the Chicago area. I want to stress that costs will be reduced by making our programs more efficient-not by diminishing the quality or amount of care we provide Chicago-area veterans. In fact, we plan to provide better, more accessible care to larger numbers of veterans.
2. **Increase Access:** VA has systemwide goals of increasing the accessibility of VA healthcare and of increasing the number of veterans receiving care from VA by 20 percent by 2002. For VISN 12, this goal equates to increasing the number of persons who use VA by approximately 28,000. That is, over the next 5 years, we would like to see the veterans healthcare system providing care for an additional 28,000 veterans in Chicago and other areas of VISN 12. To do this, we need to establish care sites that are much easier to access than the present hospitals. For example, we would like to see that veterans in high-need areas such as Austin on the West Side have much better access to VA by establishing a community-based clinic there. As you know, however, there is not expected to be any new Federal funding to achieve the goal, so if we are going to increase the accessibility of VA healthcare, then we simply have to do so by providing care more efficiently than we have in the past and redirecting the savings to expand access.
3. **Modernize VA Healthcare:** There is a need to modernize both the manner in which veterans healthcare is provided in Chicago, as well as to modernize our facilities. For example, in VISN 12, we need to invest more in fiber-optic infrastructure and computers. Again, given Federal funding realities, progress in this regard can only be achieved by finding savings in other areas. In this regard, I would again note that current state-of-the-art medical practice and new technology is allowing much more care to be provided in outpatient settings than in hospitals and that in recent years healthcare has become primarily an ambulatory activity.

4. **Optimize Utilization of VA Capital Assets:** We need to optimize the utilization of VA physical plant and capital assets to maximize the cost-effectiveness of our services. To do this, we must eliminate unnecessary duplication or redundancy of services and technology, consolidate low-volume specialty services, coordinate resource decisions better, increase telemedicine usage, and achieve better economies of scale and productivity wherever feasible. For example, one of our Chicago inpatient surgical services has an occupancy rate of about 30%, while the generally accepted standard in health care is that this should be about 85%. Maintaining such low utilization neither uses taxpayer dollars prudently nor promotes quality care.
5. **Ensure Consistently High Quality Care:** Finally, we are trying to ensure that VA provides consistently high quality care throughout the Network (as well as throughout the system). This will require more standardization of our services and better utilization of resources, including the elimination of certain low-volume services, than has occurred in the past.

Mr. Chairman, I would also take this opportunity to reaffirm my belief that both the Lakeside and West Side Divisions are essential and that I, and the Department, have no plan to close either Division. However, if we are going to achieve the five goals: 1. Reduce costs; 2. Increase access; 3. Modernize VA Healthcare; 4. Optimize utilization of VA capital assets; and 5. Ensure consistently high quality care, then there is a need to change how these facilities provide care and what specific services they each provide. I have serious concerns about suggestions that the integration process should be delayed until a complete master plan is available. Because of the decision to administratively integrate the two facilities, many work groups have been established and are planning to implement the goal of a single entity providing primary and tertiary care to the veterans of Chicago. Part of that plan has included reevaluating and assessing all equipment needs and putting them in the context of one VA. For example, there were two angiography suites planned prior to the integration at a cost of \$ 2.5 million (\$1.25 million per suite-construction and equipment) each. The work group analyzed the patient needs, location, space, etc., and decided to place one suite at West Side and eliminate the second suite. Not only did this save our VISN \$1.25 million, because the work group recommendations were able to be implemented immediately we avoided any default on contracts or any unreasonable delay in providing the angiography exams to the patients of Chicago.

There are similar issues facing several other work groups including the ordering of replacement cardiac catheterization equipment. Lakeside has had to suspend cardiac angioplasty procedures in spite of having staff well qualified and highly trained. The work group is again evaluating and is close to a recommendation. Patients for both angiography and cardiac angioplasty require referral to Hines in the interim, which can increase cost.

The two divisions have eliminated 108 positions during our hiring freeze. Many of these vacancies were eliminated either through the buy-out or attrition in expectation of the work groups recommending a smaller number of employees and less supervisors. Not filling for a short period of time has been possible, but if these work groups are not allowed to integrate services between the two divisions for any period of time, this becomes a serious problem.

There is a need for replacement radiologic equipment at VA Chicago. The radiology group has started meeting. If any of their recommendations were delayed this would also preclude the ordering of replacement equipment.

From the time the integration was administratively approved any service chief vacancy which occurred was not filled to allow for the integrated service to function without a loss of leadership. VA Chicago has eight service chief vacancies, some of these have been integrated with a single chief such as Nutrition and Food Service. To fill the others would be difficult if not impossible when applicants would know that an integration was in process. Delaying the integration of a service until all other plans are approved would be very difficult with one of the divisions having no permanent chief or supervisor. An Acting Chief can provide short term coverage but real management requires a permanent Chief.

There are plans in the VISN for another Reduction-In-Force and Staffing Adjustment of Title 38 personnel due to our continued drop in length of stay and movement to more ambulatory care. When this occurs we have been planning to use both divisions and the integrated services will allow us to move employees across the two divisions potentially avoiding some separations.

The Integration Coordinating Committee met on October 1, 1997. Final reports were given and the Committee felt their work had been completed. The chair of the ICC thanked all of the members for their work and announced that this was the final meeting as the group had completed its task. The Stakeholders Advisory Group met on October 15, 1997. The members were thanked for their valuable input and it was announced that this was the last meeting of the Stakeholders Advisory Group. Future updates to stakeholders will go through the regular mechanisms at meetings at the facilities and separate meetings at the VISN Office.

The Nutrition and Food Service work group has recommended one kitchen to serve both divisions. Delaying the closure of the second kitchen while awaiting the total plan would also delay the savings from the closure of that second kitchen. The anticipated savings from the integration are in our plan for the coming fiscal year. To delay any implementation until the entire plan is available for review by a body unknown, would also force us to look for alternative sources for those savings and may cause a higher number of RIF/Staffing Adjustment requests and may impact on patient care programs directly. At this point with the integration proceeding we would not expect any patient care program closure. We will proceed with following the Integration Coordinating Committee and Stakeholders Advisory Task Group findings and recommendations and thank you for the opportunity to present this overview.

**Historical Background
Lakeside and West Side VA Medical Centers**

COMPLEMENTARY MISSION AND SERVICES

Lakeside and West Side VA Medical Centers (VAMCs) are both predominantly acute care, highly affiliated, urban medical care facilities. Both opened in 1954 and their respective academic affiliations have been in place since then. In addition, the two medical centers serve the same patient service area. They currently share programs and affiliations in nuclear medicine, chaplain support, music therapy, and human resources management.

Lakeside VA Medical Center, located on the near north side of Chicago, offers primary and tertiary care to 460,000 veterans living in Cook County, Illinois and Lake County, Indiana. Lakeside treated 21,476 veterans in FY95 and had more than 6,600 inpatient admissions and 208,000 outpatient visits. It has 350 authorized beds, 1,200 employees, 300 volunteers and a \$96 million annual budget. Lakeside's Adam Benjamin, Jr. VA Outpatient Clinic, located 55 miles southeast of Chicago in Crown Point, Indiana, provides services to veterans (46,700 visits in FY95) in northwest Indiana. Residents and medical students who train at Lakeside rotate through the outpatient clinic as well. Lakeside services Vietnam Veterans Outreach Centers in Chicago Heights, Illinois and Gary, Indiana.

Lakeside is a member of the McGaw Medical Center of Northwestern University, which also includes Children's Memorial Hospital, Evanston Hospital Corporation, Northwestern Memorial Hospital, and the Rehabilitation Institute of Chicago. Northwestern University Medical School is Lakeside's primary affiliation for the training of 102 paid medical residents and fellows. All physician staff have faculty appointments at the affiliate. There are 22 additional affiliation agreements with 16 other institutions covering eight clinical and allied health professions. Lakeside has a diversified research program consisting of 40 VA-funded and 30 non-VA-funded investigators with 175 projects and funding of approximately \$5 million.

West Side VA Medical Center, located on the near west side of Chicago, is a 435-bed facility offering primary and tertiary care. West Side primarily serves the veterans of Cook County, Illinois, who number 411,000. West Side treated 24,781 veterans in FY95 and had more than 8,100 inpatient admissions and 280,000 outpatient visits. It has 1,570 employees and a \$123 million annual budget. West Side has three community-based off-station programs: a Veterans Resource Center, a Drug Dependency Treatment Center and the Hyde Park outpatient clinic.

The University of Illinois at Chicago is West Side's primary affiliation for the training of 129 paid medical residents and fellows. Other training programs cover such areas as dentistry, nursing, podiatry, pharmacy and other allied health professions. West Side has a research program of approximately \$1.6 million funding 20 medical investigators focusing on such areas as hematology, gastroenterology and, molecular biology.

GEOGRAPHIC AREA

Lakeside and West Side VAMCs share similar geographic and patient population areas:

- The commuting distance between Lakeside and West Side is about six miles and can be traversed by car in 10-20 minutes.
- Both facilities are accessible through a variety of public transportation networks.
- Both Lakeside and West Side draw the majority of their patients from Cook County, Illinois -- 67% for Lakeside and 90% for West Side. Another 19% of Lakeside's patients live in Lake County, Indiana, the site of the medical center's satellite outpatient clinic.
- The geographic area comprising the two medical centers and their overlapping patient populations is also the site of several Vietnam Veterans Outreach Centers and additional access points.

NATURAL PATIENT REFERRAL PATTERNS

The proximity of the two facilities has fostered a referral pattern that readily flows in both directions:

Shared patients:	3,500
Unique patients at Lakeside:	21,476
Unique patients at West Side:	24,781 (excluding fee basis)

HISTORICAL INFORMATION

- Due to their proximity (six miles and 10-20 minutes travel time), the integration of Lakeside and West Side VAMCs has been discussed for many years. In 1994, a VHA Management Improvement Task Force, one of several nationally appointed task forces, evaluated potential FTEE savings from VA medical center integrations and consolidations. The task force identified a number of potential integrations sites, including Lakeside and West Side. In March 1995, the Secretary of the Department of Veterans Affairs approved integrating sixteen (16) medical centers into seven (7). Lakeside and West Side were not included on this initial list. Since that time, the Secretary has approved three additional integrations from that list, e.g., East Orange/Lyons, Pittsburgh--Highland Drive/Pittsburgh--University Drive, and Hot Springs/Fort Meade.
- The four Chicago-area VAMCs, under the auspices of the Chicago Network Council, conducted the facility development planning (FDP) process as a single, integrated planning group. Although the plan identified the potential for integration of facilities, the Network Council took no action since the Veterans Integrated Service Network (VISN) structure was being planned nationwide and it was believed that the VISN would be the appropriate body to deal with most of these issues.
- In August 1995, the Chicago Network Council consolidated the Human Resources Management Services of Hines, Lakeside, and West Side. The consolidated Service is located at Edward Hines, Jr. Hospital. Other potential administrative service consolidations were referred to the VISN for further evaluation.
- Since the establishment of the VISN in October 1995, one of the highest priorities has been the review of the VISN tertiary care facilities for the most effective use of resources. Administrative and clinical integration and consolidation issues were discussed starting with initial visits by the VISN Director to each of the eight facilities and meetings with the Deans of the affiliated medical

schools. At the employee "town hall" meetings, which were open to all employees (including union representatives), the Network Director discussed the need to review all clinical and administrative programs, identify appropriate efficiencies, including integrations and consolidations, and evaluate the potential for improvements in resource utilization and patient care. The most commonly identified programs were cardiac surgery, angioplasty, and neurosurgery. The Lakeside and West Side meetings were held in January of 1996.

- Between November 1995 and May 1996, teams to evaluate Pathology and Laboratory Medicine, Imaging, and the development of a single Business Office for the VISN were established. The Communication Team has already implemented a computer network linking all eight of the VISN Medical Centers and is making plans for telemedicine and videoconferencing to enhance services at primary care/rural sites.
- Between October 1995 and February 1996, the Network Director met with the Deans of the six medical schools affiliated with the VISN 12 VAMCs. During these meetings, the Network Director discussed the similarities and proximity of the tertiary care facilities, clinical redundancies, and the potential for cross-facility medical residency training. Edward Hines, Jr. Hospital already has multiple affiliations, specifically with Loyola University, University of Illinois at Chicago, and Chicago Medical School.
- Both medical centers are located in the State of Illinois and therefore equally subject to the impact of existing and future state healthcare legislation. (The Adam Benjamin, Jr. VA Outpatient Clinic is located in Indiana).
- Lakeside and West Side share the same U.S. Senators (Paul Simon and Carol Moseley-Braun) and Congresswoman (Cardiss Collins).
- Both facilities share the same labor market. Both are represented by GSEU, Local 73 of SEIU. In addition the nurses at West Side are represented by the Illinois Nurses Association (INA).

SIGNIFICANT MILESTONES

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| November 6, 1993 | Joan E. Cummings, M.D. (Chairman of the Chicago Network Council and Director, Edward Hines, Jr. Hospital) testified to a subcommittee of the House Veterans Affairs Committee about the Network Facility Development Plan then being formulated by Lakeside, West Side, Hines and North Chicago VAMCs and discussed planning options, including program and facility integration among these four Chicago-area VAMCs. |
| June 1994 | Network Facility Development Plan finalized and forwarded to VHA Headquarters (then VACO). |
| August 1995 | Human Resources Management Services of Hines, Lakeside and West Side are consolidated. |
| October 15, 1995 | Position of Director at Hines became vacant. There are immediate and widespread rumors that Lakeside and West Side will be integrated. |

- January 22, 1996 Network Director visited Edward Hines, Jr. Hospital and held town hall meeting with employees.
- January 25, 1996 Network Director visited West Side VAMC and held town hall meeting with employees.
- January 25, 1996 Network Director met with the Dean of the College of Medicine of the University of Illinois at Chicago.
- January 30, 1996 Network Director visited Lakeside VAMC and held town hall meeting with employees, including teleconference hookup with employees of the Adam Benjamin, Jr. VA Outpatient Clinic in Crown Point, Indiana.
- January 30, 1996 Network Director met with the Dean of the Northwestern University Medical School.
- February 27, 1996 Network Director visited North Chicago VAMC and held town hall meeting with employees.
- February 27, 1996 Network Director met with the Dean and department chairs of the Chicago Medical School.
- March 28, 1996 Network Director met with the representatives of the Chicago area Veterans Service Organizations and discussed the issues surrounding duplication of services. The Network Director emphasized the VISN position that the special needs of psychiatry and rehabilitation patients preclude closure of any facility. Consolidation of medical/surgical inpatient services between the two Chicago VAMCs was identified as requiring study by the VISN.
- March 29, 1996 Network Director met with a group comprising the Dean or his representative from five of the six medical schools affiliated with VISN VAMCs (the Dean from the University of Wisconsin was unable to attend). The issue of medical/surgical inpatient services in Chicago was reviewed at length, including discussion of closure of beds at either Lakeside or West Side and increased use of the beds at Hines. The group discussed the creation of a committee, whose members would have no links to Lakeside or West Side, to assess and make recommendations to the Network Director regarding the placement of the medical/surgical inpatient services.
- April 1, 1996 Network Director met with the staff of the Chicago area Congressional delegation. The clinical redundancies, as discussed with the Veterans Service Organizations, were presented, including the proposed evaluation of the placement of acute medicine and surgery inpatient services.
- April 7, 1996 The position of Director at West Side became vacant with the transfer of John DeNardo to the position of Director of Edward Hines, Jr. Hospital.

- April 16, 1996 Network Director briefed Secretary Brown and his staff on discussions concerning the potential for an integration of Lakeside and West Side in preparation for the Secretary's meeting with Congresswoman Cardiss Collins and Dr. Gerald Moss, Dean of the College of Medicine of the University of Illinois at Chicago.
- April 17, 1996 A newspaper for the faculty, staff, and students of the University of Illinois published an article opposing consideration of facility integration.
- April 24, 1996 Network Director held a second meeting with Dean Moss, University of Illinois, and discussed integration issues, particularly the integration of Lakeside and West Side and the concept of multiple medical school affiliations.
- May 8, 1996 An article regarding the possible integration of Lakeside and West Side appeared in the Business Section of the *Chicago Tribune*.
- May 13, 1996 Network Director had a discussion with Dr. Harry N. Beaty, Dean of Northwestern regarding the potential for integration. The University is very concerned regarding the maintenance of training programs with VA and wishes to work with the VISN on the implementation of any plans for integration. Dr. Cummings stated her appreciation of the University's position and assured him that they would be full partners in the process.
- May 13, 1996 Letters were sent to the Unions by the Director of Lakeside and the Acting Director of West Side informing them of the potential for integration.
- May 13, 1996 Network Director sent letters to the stakeholders such as VSOs, Congressional delegation members and affiliated medical schools informing them of the planning for a possible integration of Lakeside and West Side VAMCs.
- June 27, 1996 Secretary of Veterans Affairs Jesse Brown announced his decision to integrate the Lakeside and West Side VAMCs under a single management structure.
- September 12, 1996 Network Director met with James A. Balcer, Director/Community Liaison, City of Chicago to provide the Mayor's Office with an overview of the integration.
- September 26, 1996 Network Director met with members of the Minority Veterans Steering Committee and the Montford Point Marine Association to provide them with an update on the integration.
- October 28, 1996 First meeting of the VA Chicago Health Care System Integration Coordinating Committee chaired by Dr. Christopher Terrence, Chief of Staff, VA New Jersey Health Care System. Subsequent meetings have taken place on December 1, 1996, January 29, 1997, March 5, 1997,

April 23, 1997, June 4, 1997, July 16, 1997, and August 20, 1997. The last meeting of the Committee was held on October 1, 1997.

October 28, 1996

First meeting of the VA Chicago Health Care System Stakeholders Advisory Group, chaired by George Cramer, Assistant Director, Illinois Department of Veterans Affairs. Subsequent meetings have taken place on December 4, 1996, February 20, 1997, May 7, 1997, July 30, 1997, and September 3, 1997. The last meeting of the Committee was held on October 15, 1997.

STAKEHOLDER AWARENESS

Background

Prior to the implementation of the VISNs in late 1995, the Chicago area VA facilities operated with a Network Council. A representative of the Veterans Service Organizations and the affiliate Deans as well as the VBA Regional Office Director were members of the Council. The management teams of these facilities recognized that, because of their geographic locations, planning needed to be done as a unit. The Chicago Network Council worked to develop a Veterans Health Administration (VHA) health care plan for the four VA facilities in the Chicago area: Hines, Lakeside, North Chicago, and West Side. The goal was a health system that would enhance service to veterans while minimizing the costs and inefficiencies inherent in operating four hospitals with similar missions in close proximity. To this end they adopted several assumptions which remain relevant in the current VISN. These assumptions include:

- All patients are Network patients and are not identified as patients of a specific facility, but identified by physician providers.
- All resources flow through the Network including resident allocation.
- Primary care sites are the entry points for the Network. New Network participants are possible.
- Facilities will be developed to meet the Network integration strategy.

These issues will be continually discussed with stakeholders in the months to come.

Discussions will be occurring against the backdrop of the current negotiations over balancing the Federal budget as well as the wide-ranging debate over the future of the nation's health care system and how VA would fit into a reformed health care delivery system. Although the focus of the health care debate has shifted somewhat to the states since 1994, its impact on the importance of facility and/or service integration remains high.

Status

Stakeholders will continue to be apprised of developments concerning the integration process by the Network Director. She has had several telephone conversations with staff members of the Congressional delegation and the news media and will continue to be available as needed. Network staff will continue to respond as rapidly as possible to letters of inquiry and other requests for information.

Veterans Service Officers, Commanders, and Representatives

Ongoing dialogue about service integration will continue to take place with representatives of various Veterans Service Organizations during each facility's regularly scheduled meetings. The Network Director will also continue to have frequent communication with these important stakeholders. The following organizations will be included in this dialogue:

- The American Legion
- AMVETS
- Disabled American Veterans
- Jewish War Veterans
- Military Order of the Purple Heart
- Paralyzed Veterans of America
- Veterans of Foreign Wars
- Vietnam Veterans of America
- Montford Point Marine Association
- Minority Veterans Affairs Steering Committee
- Others

Congressional Representatives

The Network Director will continue to keep all Congressional representatives involved in and apprised of the integration discussions.

Employee Relations

A key factor in any plan to integrate services is the impact on staffs at both Lakeside and West Side. Management will continue to keep employees informed of ongoing developments through staff meetings, newsletters, and other forums.

The GSEU, Local 73 of Service Employees International Union (SEIU) represents employees at both facilities. The Illinois Nursing Association (INA) also represents nursing personnel at West Side. The unions will continue to be informed about integration discussions.

Medical School Affiliates

Northwestern University Medical School and the University of Illinois at Chicago College of Medicine, will continue to be involved in and apprised of discussions concerning integration.

CURRENT STATUS AND ISSUES

1) Integration of

- medical inpatient services,
- surgical inpatient services,
- ambulatory care and access points,
- physical medicine and rehabilitation services,
- mental health services,
- pathology and laboratory medicine,
- dental,

- information resources management, and
- administration.

2) The University of Illinois has voiced strong opposition to the consideration of integration of these two facilities.

3) Northwestern University is equally concerned but wishes to work with the VISN staff to effect necessary program changes.

4) The June 27, 1996 announcement by VHA Headquarters to integrate the Lakeside VAMC and West Side VAMC initiated the process to establish an Integration Coordinating Committee to oversee and coordinate:

- developing a single management team,
- developing a unified mission and vision,
- developing recommendations for reducing unnecessary service duplication,
- fostering maximum cost effectiveness, quality, consolidation and satisfaction,
- integrating Decentralized Hospital Computer Program (DHCP) databases,
- developing an organizational chart.

EVALUATING AND MONITORING THE PLAN

An evaluation and monitoring plan will include:

- customer service
- resources utilization
- quality of care
- access
- timeliness

REPORTS AND RECOMMENDATIONS FROM THE INTEGRATION COORDINATING COMMITTEE (ICC)

- Reviewed reports and recommendations from 13 of the 14 ICC-chartered work groups for the following services and submitted recommendations and comments to the VA Chicago Health Care System (VACHS) Director:

<i>-information resources mgmt.</i>	<i>-nuclear medicine</i>	<i>-ambulatory care</i>
<i>-nutrition & food</i>	<i>-neurology</i>	<i>-medicine</i>
<i>-pathology & laboratory</i>	<i>-physical medicine & rehab</i>	<i>-psychiatry</i>
<i>-diagnostic radiology</i>	<i>-research</i>	<i>-surgery</i>
<i>-anesthesiology</i>	<i>-therapeutic radiology</i>	

- Reviewed reports and recommendations of 18 integration work groups for the following services and submitted recommendations and comments to the VACHCS Director:

<i>-audiology & speech pathology</i>	<i>-fiscal/MCCR (cost recovery)</i>	<i>-police & security</i>
<i>-chaplain</i>	<i>-hospital based primary care</i>	<i>-prosthetics</i>
<i>-dental</i>	<i>-library</i>	<i>-psychology</i>
<i>-education</i>	<i>-medical administration</i>	<i>-recreat'l therapy</i>

-engineering
-environmental mgmt.

-nursing
-pharmacy

-social work
-voluntary

- Recommended a VA Chicago Health Care System integration goal statement (approved)
- Recommended a VA Chicago Health Care System mission (approved)
- Endorsed consolidation of several administrative and clinical services, including audiology and speech pathology, chaplain, dental environmental management, hospital based primary care, information resources management (approved), neurology, nuclear medicine, nutrition and food services (approved), pharmacy (approved), police and security services, prosthetics and voluntary (approved) services.
- Recommended angiography equipment replacement at West Side and cardiac catheterization equipment replacement at Lakeside (both approved)
- Recommended integration of pathology and laboratory medicine services
- Recommended integration of ambulatory care services at the two divisions, including satellite outpatient clinic sites (Crown Point, Indiana, and 63rd and Stony Island, Chicago).

INTEGRATION IMPLEMENTATION ACTIVITIES RECOMMENDATIONS FROM THE STAKEHOLDERS ADVISORY GROUP (STAG)

- Single director (vs. two facility directors previously), VACHS.
- Merged Lakeside and West Side divisions clinical and administrative computer databases (DHCP- Decentralized Hospital Computer Program) into a single VA Chicago Health Care System computer database
- Consolidated medical care cost recovery section staff of Fiscal Service at West Side Division
- Consolidated payroll section staff of Fiscal Service at Lakeside Division
- Appointed single Chief, Information Resources Management Service for both divisions
- Appointed single Chief, Pharmacy Service for both divisions
- Appointed single Chief, Recreation Therapy Service for both divisions
- Appointed single Chief, Voluntary Service for both divisions
- Appointed one Information Systems Security Officer for both divisions
- Appointed two Decision Support System persons for both divisions
- Estimated cost savings identified to date in VACHS Director-approved work group reports: \$691,000 (13.8 FTE)

STATEMENT OF
JOSEPH L. MOORE
DIRECTOR
VA CHICAGO HEALTH CARE SYSTEM
ON INTEGRATION AND CONSOLIDATION
OF VA MEDICAL FACILITIES IN CHICAGO
BEFORE
THE
SUBCOMMITTEE ON OVERSIGHT AND INVESTIGATIONS
COMMITTEE ON VETERANS' AFFAIRS
CHICAGO, ILLINOIS
OCTOBER 16, 1997

Mr. Chairman and Members of the Subcommittee:

I welcome the opportunity you have provided me to testify at this Field Hearing, for this is a meeting -- and a topic -- whose significance cannot be overstated.

The facility integration that we have convened to discuss is the first -- and, thus far, the only one -- of its kind. Moreover, despite challenges from within and without, the VA Chicago Health Care System is moving steadily forward. Indeed, we are making history. More importantly, we are making the changes necessary to continue providing our area's veterans with the comprehensive, compassionate health care that is their due.

I am going to speak of faith as it is defined by Webster's: "the firm belief in something for which there is no proof." When we embarked upon this journey, my faith -- in veterans, in the VA and in the merits of the task before us -- assured me of our mission's eventual success. Naysayers predicted this would not work; I stand before you with my faith intact.

We have established a sound, solid foundation upon which to build as the inherently dynamic process of facility integration continues to unfold before us.

I would like to begin by giving you some background, after which I will update you on where VA Chicago stands today -- and where I see us headed tomorrow.

As member institutions of Veterans Integrated Service Network (VISN) #12, the former VA Lakeside and VA West Side Medical Centers had much in common right from the start. These two predominantly acute-care, highly affiliated, urban medical facilities were approximately the same age; their respective academic affiliations began at about the same time; they had similar geographic and patient population areas; and, prior to their integration, they already shared programs in several services.

On June 27, 1996, then-Secretary of Veterans Affairs Jesse Brown announced his decision to integrate Chicago's two VA Medical Centers under a single management structure. (The name change to the VA Chicago Health Care System followed on October 1 of that year.) Given recent and anticipated developments both within our nation's health care industry and at the federal funding level, it was envisioned that the two Chicago facilities would be stronger as a single, unified institution than they had been as two. Through the pooling, reorganization and reallocation of our resources according to where they could best be utilized, we at Lakeside and West Side could eliminate redundancies, enhance operational efficiency, conserve resources and maximize their utilization, ensure the continuation of high quality care during a period of declining resources, and perform our assigned roles in the continuum of care established, by our VISN, for the veterans in our geographic area.

In short, the Department of Veterans Affairs sought to establish in VA Chicago a fully integrated health care system that would cost-effectively provide a single, high standard of care for the veteran patients who are VA's very reason for being.

On January 1, 1997, the Lakeside Division and West Side Division computer databases were merged, thereby forming one of the largest facility databases in the Department of Veterans Affairs. Residing at the West Side Division, the database's hardware is connected via telecommunication links to VA Chicago's other sites.

While merging our databases was accomplished with relative ease, merging our other resources, human and otherwise, has required greater effort -- as well as the input of many different partners. The Integration Coordinating Committee (ICC), operating under my oversight, set about reviewing the activities of the 32 service-specific work groups under its purview, while the Stakeholders Advisory Group (SAG) provided input and advice from representatives of our various publics, including local US Congressional offices. These committees and work groups focused on such basic criteria as value of care, access to care, quality of care, customer satisfaction, and cost savings and avoidances.

As of two weeks ago -- October 1, 1997 -- the ICC completed their assigned task of structuring the Lakeside/West Side integration. Yesterday, October 15, 1997 the SAG completed its work. Although

disbanded at the facility level our stakeholders will continue to have a voice through our VISN's stakeholders advisory group. The medical school deans of our two major academic affiliates, Northwestern University and the University of Illinois, are now working together closely. In the weeks ahead, we intend to establish an integrated Deans' Committee drawn from the respective bodies at both universities. Guided by this new group, we will continue to forge our ongoing integration, particularly in the areas of medical education and residency training.

Also on October 1, the 16th service chief was formally appointed to oversee operations throughout the VA Chicago Health Care System. Drawn from both divisions in perfectly equal measure, these VA Chicago chiefs -- and their divisions of origin -- are as follows:

Audiology and Speech Pathology: Kyle Dennis, PhD (West Side Division)

Chaplain: Howard Jones (Lakeside Division)

Engineering: Ronald Hughes (Lakeside Division)

Environmental Management: Lenwood O'Neal (Lakeside Division)

Information Resources Management: Howard Loewenstein (West Side Division)

Library Service: Lydia Tkaczuk (Lakeside Division)

Medical Administration: Sylvia Courtney (West Side Division)

Nursing: Joe Caldwell, RN (Lakeside Division)

Nutrition & Food: Gracie Bradford-Specks (Lakeside Division)

Pharmacy: Richard Rooney, PharmD (Lakeside Division)

Police and Security: James Curry (West Side Division)

Prosthetic and Sensory Aids: Robert Baum (Lakeside Division)

Psychology: George Meschel, PhD (West Side Division)

Recreation: John Clifton (West Side Division)

Social Work: Timothy Buckley (West Side Division)

Voluntary Service: Marie Bambakakis (West Side Division)

These chiefs are responsible for overseeing and coordinating the operations of their respective services at both divisions, as well as carrying out fully their commitments in the labor/management arena.

Within those services that have not yet been formally restructured, the service chiefs and staff at both divisions are closely coordinating their efforts in order to ensure that our veteran patients receive the maximum possible benefit from our shared resources.

To date, the two divisions have eliminated a substantial number of positions, primarily through buy-outs, attrition and unfilled vacancies -- without, I would stress, either the forcible termination of a single employee or even the slightest reduction in our provision of patient care. While not a function of the integration, the diminution of our work force certainly "forces the issue," obliging our two divisions to pool their programs and resources in order to maximize not only the efficiency and cost-effectiveness but also the quality of the services that we at VA Chicago provide.

Indeed, such a maximization of resources is essential in order for us to fulfill our institutional mission:

- To provide seamless, comprehensive (primary and tertiary), compassionate, timely and cost-effective health care for the Chicago (Cook County) and northwest Indiana veterans at each of the divisions and clinics of the VA Chicago Health Care System.
- Together with our academic and staff affiliates, to capture the innovative opportunities offered by the integration of the two divisions in enhancing the delivery of health care, education and research.
- To develop programs and resources which enhance our ability to provide comprehensive services.
- To provide primary back-up for active military personnel in a war or national emergency.

Fortunately, VA Chicago's multiple academic affiliations and great size give us the means and flexibility needed to offer our veterans truly exceptional care. What's more, this care is provided by first class practitioners: in *Chicago Magazine's* recent list of the area's "Top 500 Doctors," 72 physicians -- one in seven -- practice at VA Chicago.

Thus equipped, the management and staff at both sites have a unique opportunity to work together toward a fully integrated and cohesive health care system for the veterans of Cook County and the surrounding area, directing our pooled programs and resources to more patients and into more types of services than ever before.

Already, some major pieces are falling into place. The West Side Division recently installed a new, greatly improved angiography suite, and the Lakeside Division has purchased the equipment needed for a state-of-the-art cardiac catheterization laboratory. In addition, an innovative and cost-effective residential substance abuse program has been instituted at our West Side Division. Facilities and programs like these -- to name but three -- promise to enhance our overall capability as VA Chicago.

It is, I think, important to keep in mind that never before have two major, highly affiliated, tertiary-care VA medical centers been integrated under a single management structure. It thus came as no surprise that the scrutiny given our efforts by the media, the community, aldermen and clergy, our employees, their labor

unions and the community at large -- not to mention the General Accounting Office and numerous VA Health Systems Researchers -- has been and continues to be so intense.

Some union representatives have taken issue with management's rights (as affirmed in US Code, Title 5, Subpart F, Section 7106) to make the decisions needed to bring facility reorganization to fruition. However, I believe that as labor continues to grow in its understanding of this dynamic process, so too will its capacity to work in partnership with us to effect the best possible outcome for all concerned. Furthermore, Northwestern University and the University of Illinois have often been depicted as in conflict, when a more accurate portrayal would show the two institutions concurrently and, of late, cooperatively facing a common challenge.

Likewise, there have been claims -- widely reported in the media -- that all inpatient service would be transferred to Lakeside, or that West Side would be closed outright. In fact, our position remains unchanged: both facilities will come out of this initiative *stronger* than they were before, in order that we might more fully address all of our patients' needs.

We have been edified by the examples of other institutions -- up to a point. Each facility brings into the mix its own unique history, philosophy and patient population; every integration poses its own challenges and engenders its own lessons. Each such venture is an exploration, a journey into virgin territory; those who work to accomplish facility integration are, by definition, pioneers. Thus, more than anything else, the extent of our success will be determined by our openness -- by our willingness and ability to learn.

In his report on behalf of our Surgery Work Group, which he chaired, Dr. Charles Rice, Vice Dean of the University of Illinois Medical School, used words that apply, I would contend, to VA Chicago as a whole. -- "A plan of consolidation involving two complex services," he wrote, "cannot be complete in every detail. The plan should be a template for an ongoing process. The goodwill and good faith that were established in the development of this consolidation plan bodes well for the future as means of coordinating and enhancing services are sought. In the past, organizations strategized to gain a competitive advantage. We want this consolidation to give us a cooperative advantage.--"

That "cooperative advantage" is precisely what VA Chicago has sought all along. Seeing it take shape in new and unprecedented ways -- ways that are geared, invariably, toward enhancing patient care -- is the most gratifying reward that any of us could hope to receive.

Facility integration means change, and change invariably invites criticism, particularly from those with a vested interest in maintaining the status quo. Yet when we committed to this course, we understood that change -- not cosmetic tweaking but intrinsic, significant change, major surgery -- necessarily would become our new, day-to-day reality. And so it must if we as a health care system are to not only survive, but thrive.

Our nation is home to 26 million men and women who, at various times throughout this century, put their lives on the line to protect and defend the cherished freedoms of which each and every American partakes daily. These unselfish and, all too often, unsung heroes did not shrink from their call to duty; they stepped forward and paid the price for your freedom and mine. Who among us would suggest that we now shrink from the challenge before us -- and, thus, from our commitment to them?

While our institution has been and continues to be in transition, one great constant remains: our mission of caring. In the final analysis, it is our very ability *to* change -- in line with our newly-developed "cooperative advantage" -- that will allow us to not only maintain but fortify this mission of caring today, tomorrow and well into the next century. Our veterans deserve no less.

STATEMENT OF
CHRISTOPHER F. TERRENCE, M.D.
CHAIRMAN, INTEGRATION COORDINATING COMMITTEE
VA CHICAGO HEALTH CARE SYSTEM
BEFORE
THE
SUBCOMMITTEE ON OVERSIGHT AND INVESTIGATIONS
COMMITTEE ON VETERANS' AFFAIRS
CHICAGO, ILLINOIS
OCTOBER 16, 1997

Mr. Chairman, other speakers and guests - Good morning and thank you for this opportunity to discuss the Integration Coordinating Committee (ICC) of the VA Chicago Health Care System. On October 10, 1996, I was charged by Kenneth Kizer, M.D., MPH, Under Secretary for Health, to be the Chair of the Integration Coordinating Committee for the VA Chicago Health Care System. In his letter of appointment Dr. Kizer stressed that there were "no preset determinations. The process should be open and data driven and that all reports and recommendations reviewed by the VISN Director, Joan E. Cummings, M.D., and subsequent review at the Under Secretary of Health level." One of the guiding principles that the Integration Committee shared early on in the process was the need for maximum involvement of the affiliates, the stakeholders, employees, and other interested individuals. As of today over 300 individuals in the VA Chicago Health Care System have had input into the ICC's process either as a member of the committee, subcommittee or Stakeholders Advisory Group.

At its first meeting, the Integration Coordinating Committee decided that we would proceed in forming chartered work groups with the approval of the Medical Center Director, Mr. Joseph Moore. These groups were service specific and were charged with developing a health system that would maintain the quality or enhance the overall service to the veterans while minimizing the costs inherent in operating two hospitals with similar missions in close proximity. The committee decided to start with services that were relatively non controversial in order to prove that the process was valid, and could be accomplished in the context of the VA Chicago Health Care System. When a group completed its proposal, the proposal was submitted to the Integration Coordinating Committee for its review and subsequent recommendation to the Medical Center Director. The proposal was also reviewed at the Stakeholders Advisory Group by the chairmen of the various chartered work groups. The recommendations from the Stakeholders Advisory Group were brought forward to the ICC in order to provide maximal input into the deliberations of the Integration Coordinating Committee.

2.

The various work groups were usually chaired by a chief of service, but in some instances such as surgery, medicine and psychiatry, the group was chaired by a University of Illinois School of Medicine representative or a Northwestern University Medical School representative.

In order to keep the staff at the two divisions up-to-date on the process of the committee, we have used a number of formats to achieve this goal. The Chair of the Integration Coordinating Committee has had four town hall style meetings at the Lakeside and West Side divisions. These meetings had two goals, (1) to present the activities of the Integration Coordinating Committee and (2) to seek information from the staff at the two divisions concerning the future process of the Integration Coordinating Committee. These meetings were extremely well attended and were very informative. There has also been regular updates of the progress of the Integration Coordinating Committee in the VA Chicago Health Care System Newsletter, as well as publication of the Integration Coordinating Committee minutes in the decentralized hospital computer program (DHCP). At the last town meeting it was also suggested that we have a newsletter put on the DHCP.

By October 1, 1997, all the work groups have presented their recommendations to the Integration Coordinating Committee. Most of the recommendations have been forwarded to the Medical Center Director with little changes. A few have been referred back to the service work groups. As one can see the process is very time consuming, but the committee believes that it is very worth while in that it involves the maximum number of people in the proposing process. Until the inception of the Integration Coordinating Committee, there had been little active participation by the two divisions in coming up with joint plans as to consolidation.

The ICC has approved the Goals & Mission statement for the VA Chicago Health Care System. In addition the committee has also recommended the replacement of angiography equipment at the West Side Division, and the replacement of the cardiac catheterization equipment at the Lakeside Division. The committee has also recommended the integration of Ambulatory Care Services at the two divisions which will include the satellite outpatient clinics at Crown Point, Indiana, and 63rd Street and Stony Island in Chicago.

The committee has built up a track record of accomplishment which has allowed us to deal with the thorny issues of affiliation interests and placement of bed service facilities. In order to facilitate the process among the bed service working groups, the Medical Center Director and I have had meetings with the Chairs of the bed service chartered work groups to facilitate the interservice planning that was necessary for a coherent proposal.

3.

In summary, I believe that the Integration Coordinating Committee of the VA Chicago Health Care System has worked very diligently in setting up a process and frame work for the integration of two tertiary care hospitals. This committee would have never been successful without the support of the four medical school Deans, the union representatives who have contributed greatly, the chair of the stakeholders group and other veterans service organization representatives.

Thank you for the opportunity to present this brief overview of the Integration Coordinating Committee of the VA Chicago Health Care System.

**The
American
Legion**



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November 4, 1997

Honorable Terry Everett, Chairman
House Veterans' Affairs Subcommittee on
Oversight and Investigations
335 Cannon House Office Building
Washington, DC 20515

Dear Chairman Everett:

In lieu of personal testimony, The American Legion Department of Illinois is submitting a written statement relative to the Integration and Consolidation Planning of The Department of Veterans Affairs Medical Facilities in Chicago. The American Legion requests that this statement be made part of the October 16, 1997 hearing record.

We appreciate your compliance with this request.

Sincerely,


Kimo S. Hollingsworth, Deputy Director
National Legislative Commission

**TESTIMONY OF MARTIN F. CONATSER
DEPARTMENT COMMANDER
THE AMERICAN LEGION OF ILLINOIS
TO THE
SUBCOMMITTEE ON OVERSIGHT AND INVESTIGATIONS
COMMITTEE ON VETERANS' AFFAIRS
UNITED STATES HOUSE OF REPRESENTATIVES
ON
INTEGRATION AND CONSOLIDATION PLANNING OF THE DEPARTMENT OF
VETERANS AFFAIRS MEDICAL FACILITIES IN CHICAGO**

NOVEMBER 4, 1997

Mr. Chairman and Members of the Committee:

The American Legion expresses gratitude and appreciates the opportunity to share its views on the integration process of the VA Chicago Health Care System (Lakeside/West Side Divisions). The mission of the Department of Veterans Affairs (VA) Chicago Health Care System is to provide quality medical care for Chicago area veterans.

A GAO report, Lessons Learned From Medical Facility Integrations, July 1997, stated "facility integrations are a critical piece of VA's overall strategy to enhance the efficiency and effectiveness of health service delivery to veterans. VA's strategy is similar to how the private sector health care industry is evolving. In essence, integrations can allow VA to provide the same or higher quality services to veterans at a significantly reduced cost." It further states that within a short period of time by unifying management and consolidating services, the integration of Westside and Lakeside would produce millions of dollars in savings that then could be reinvested in the VA system to further enhance veterans care.

On the other hand, an article in Hospital & Health Networks by Chuck Appleby titled Organized Chaos states "whether working in hospitals, clinics or private offices, doctors, nurses and other staff typically go about their work in an ad hoc fashion that relies more on oral history-the way we've always done it- than on bona fide studies of efficiency. Welcome to the world of clinical integration, which is still more theory than practice". In the opinion of The American Legion, this is more typical of the integration process between West Side and Lakeside in Chicago.

The buzz words often heard here are "data driven". However, the reality of the situation points out that in some cases consolidations have been more motivated by budget than quality. This is what The American Legion sees in this case. Budget driven consolidations can result in hardships, and can be harmful to patients. The biggest threat, under these conditions, is the reduction or elimination of services and professional staff. Examples of services that have been eliminated or reduced with other such integrations include inpatient and outpatient Mental Health, Substance Abuse, and PTSD programs.

In the field of Substance Abuse programs, The American Legion has already seen the reduction of the number of patients treated; as inpatient wards close forcing longer commuting distances for patients seeking inpatient treatment. Studies conducted by the VA have found that increasing travel distances by 20 miles can reduce the likelihood of outpatient follow-through by approximately 70 percent. In urban areas, increasing the distance by 10-15 miles incurred significant drop-out by low income minority and /or veterans over the age of 60. Also, there has been a significant drop in resources across-the-board in funding for substance abuse program which includes the reduction of staff. There are facilities which justified closing their inpatient capabilities by claiming to reduce

redundancy, and the intent to reinvest their savings into outpatient programs or community outreach programs. In many cases, that has not happen. In the field of mental health, resources have also been diverted from mental health programs to non-mental health programs. These observations were confirmed by clinicians that The American Legion interviewed while in the field and by VA Headquarters staff. The American Legion has additionally, confirmed these observations with statistics from the Performance Measures for Seriously Mentally Ill Veterans FY 1996, Department of Veterans Affairs Outcome Monitoring of VA Specialized Intensive PTSD Programs Fiscal Year 1996, and the Department of Veterans Affairs National Mental Health Program Performance Monitoring System Fiscal Year 1996 Report.

The American Legion is concerned about the current reduction of employees (about one hundred) at these two divisions, as well as plans for another round of employee reduction in the coming year. VA has already halted the construction of suites intended to provide specialty vascular testing for patients. Patients in need of advanced vascular testing are now forced to travel outside of Chicago to Hines Medical Center in west suburban Maywood. Again, The American Legion must repeat that researchers have shown that distance or travel time between patient's home and the hospital is the most important determining factor whether a veteran will use a VA or non VA facility. Further cutbacks are supposedly planned over the next year, and The American Legion is concerned the cutbacks will negatively affect the quality of medical care available to Chicago area veterans.

The American Legion has concur with the premise of the MCMANIS Associates report that stated stakeholder participation in the process would have been enhanced if VA had provided a detailed integration plan before implementation of the integration began. Some of the problems with winning early support of The American Legion were because VA did not provide sufficient information about the integration, such as how services will be integrated; how potential changes will affect veterans and employees; why selected alternatives are the best ones available, how much the potential changes will cost to implement, how much the potential changes will save, and how VA will reinvest savings to benefit veterans. This is especially important since the Lakeside and West Side facilities have almost identical missions, are about the same size, and have strong affiliations with major medical schools. Even though there is ample evidence that the VA made an effort to keep veterans, employees and stakeholders informed of changes, The American Legion believes the timing of the effort was too little and too late. During a Field Service site visit by the national staff of The American Legion's National Veterans Affairs and Rehabilitation Commission in September, not one individual could be found who could satisfactorily answer most of the above questions.

The previously cited GAO report mentioned that the "VA's incremental planning approach contributes to these communication problems because it limits the amount of information available about the integration before implementation begins. Providing this information would enable VA to communicate more effectively with stakeholders. Moreover, presenting such planning results in a written document that could be shared with stakeholders would further enhance the opportunity for effective communication by allowing VA to obtain stakeholders views and gain support or "buy-in" for its proposed integration activities.

Christopher F. Terrence M.D. Chairman, of the Integration Coordinating Committee reported that during their planning process the decision was made to form work groups. "The goal of the work groups to produce a health system that would maintain the quality or enhance the overall service to the veterans while minimizing the costs inherent in operating two hospitals with similar missions in close proximity". He explained how these work groups would study how to integrate individual services, then make their recommendations to the main Integration Coordinating Committee and then on to approving authorities. The

American Legion questions how well these individual work groups will be coordinated to provide a unified master plan. The American Legion concurs with the GAO report which recommended that "VA's decision-making may be enhanced if it completes all planning for the integrated facilities before beginning to implement the integrations". A master plan would have resulted in giving the VISN an even greater monetary savings which would have then allowed greater reinvestment opportunities, along with reducing the interest of third parties. This would have gained greater acceptance by The American Legion.

The American Legion agrees with the concept of the VISN 12 vision of the integration of Lakeside/West Side as one element of a larger Network strategy aimed at accomplishing five principal goals to reduce costs, increase access, modernize VA healthcare, optimize utilization of VA capital assets and ensure consistently high quality care. The American Legion is aware that the elimination of unnecessary duplication or redundancy of services, and the coordination of resource decisions will achieve better economies of scale and productivity. The American Legion agrees with the approach. However, chartered work groups, chaired by a chief of service in some instances, a University of Illinois representative, or a Northwestern School of Medicine representative seems to have brought an air of mistrust among hospital staff of both facilities. Subsequently, any decisions from these groups given their composition may reflect the chairperson's own interests (as correctly pointed out by the GAO report).

The American Legion wants to ensure that both the Lakeside and West Side Divisions remain open and that both divisions continue to serve Chicago area veterans on both an inpatient and outpatient basis.

**TESTIMONY
FROM**

**THOMAS A. DUNCAN, JR.
EXECUTIVE DIRECTOR**

AND

**ROBERT H. WHITE
NATIONAL DIRECTOR**

**ON BEHALF OF
VAUGHAN CHAPTER**

**PARALYZED VETERANS OF AMERICA
OCTOBER, 1997**

My first experience with the Integration of the Chicago land Department of Veterans Affairs Hospital was very chaotic and disorganized. Reaction to Congress mandated to balance the budget no matter what. As a result, the VISN Director appeared to dictate "RIFF" integrations over West Side/Lakeside Hospitals. Closing of departments without considering the fact of the VA employees, the community, the veterans, the unions, and the veterans service organizations who represent the VA constituency.

It wasn't until PVA, Vaughan Chapter, took the initiative to call for a meeting at the request of the community leaders at the University of Illinois, and the unions, to bring some sense of order to the issue of integration.

PVA's, Vaughan Chapter's, position from the beginning was that an environmental impact study should be conducted as related to the veterans, the employees, the community, and all of those who had a stake in the effect of any changes occurring in Chicago.

After a great amount of dialogue and meaningful exchanges between administration and the veteran service organizations, it was finally conceived that the best way to make any changes was to involve all the principals previously mentioned. As a result, you have one organized concept that you are now utilizing to make a smooth integration. Such as; the Integration Coordinating Committee, Veterans Advisory Council, Stakeholders Advisory Group, and the SCI Advisory Task Group.

We further feel that the expiration of the Integration Coordinating Committee's Commission and the end of the Stakeholders Advisory Group's mission, leaves no representation for the community and consumers in an oversight position as change takes place at Chicago Lakeside/West Side VMAC.

Now that a method seems immediate on the Integration of the Chicago Lakeside/West Side VMAC, there should be an oversight mechanism to ensure that all concerned continue towards the agreed goals of the Integration Coordinating Committee. For without this oversight of the integration process, there may be a tendency or at least the opportunity for those charged with the integration changes to lose perspective of the projected goals. Further there may be a tendency to stray from the pressures of cost cut backs, increased patient load, and modernization. Because of the reductions in funding that are planned over the next three (3) fiscal years, there is even more reason to maintain the consumer safeguards that have been put in place by the entities involved. We must all stay the course directed by the committees in order for it to work for all concerned.

In closing, for all else to work, there must be a continuation of the oversight by the Stakeholders Advisory Committee at Chicago Lakeside/West Side VMAC. This group is the most diversified and contains all needed elements for complete oversight.

We at Vaughan Chapter PVA feel that this should have been done in the beginning; that this concept should be used throughout all the VISN's for effective change.



Northwest Chicago Senior Citizens Legislative Council

Chicago Department on Aging Copernicus Center

3160 North Milwaukee Avenue, Chicago, Illinois 60618 (773) 744-6681

Meetings 9:30 a.m. - 11:00 a.m. second Friday of the month

Wards 30, 31, 32, 33, 35, 36, 38, 39, 41, 45

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TESTIMONY

TO : CONGRESSIONAL COMMITTEE ON VETERANS AFFAIRS

FROM : IRVIN R TCHON RPH. Member 4th Congressional Veterans Advisory Board, President Chicago Senior Legislative Council, AMVPTS Post #34, Polish Legion American Veterans, Post #82, Disabled American Veterans and China Burma India Hump Pilots Assoc.

Proposed plans for the Westside and Lakeside VA Hospital facilities in Chicago appear to be serving accounting and cost savings, rather than clinical functions, quality care community accessibility and transportation. The emphasis should be on NEED and not SAVINGS.

The VA Plan appears to be an attempt, to treat the whole person by REACHING BEYOND THE FORMER TRADITIONAL MEDICAL DIAGNOSIS, to assist and assess the economic, social, functional problems and psychological problems that affect Veterans. This is a positive forward beneficial course of the V.A.. Modern Computer Technology can now measure success and quality being delivered and future changes required.

Major Health Services, which are operating below capacity should be converted into Nursing Homes and Retirement Homes. Research funding for Teaching Medical Centers should be continued. Hospitals should be Outpatient and the use of their satellite clinics be part of the system. Hines VA should be the Major Hospitalization Center for the Westside and Lakeside Hospitals.

The Veteran Organizations and Volunteers serving the V.A. should be enlarged and subsidized adequately as to provide a core of compassionate, caring and assisting segment to THERAPY and MONITORS of VETERAN HEALTH DELIVERY.

Sincerely yours,

Irvin R. Tchon RPH
IRVIN R TCHON RPH

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GOD BLESS AMERICA and AMERICAN VETERANS

PROGRAMS

Memorial Day, Flag Day, 4th of July, Labor Day, Veterans Day, Hospital Visitations

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