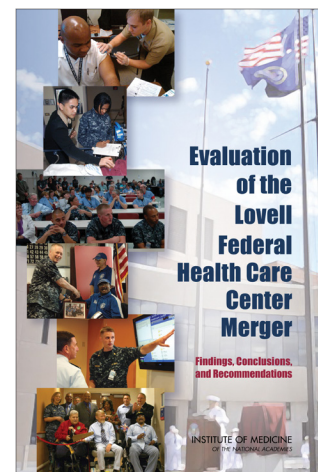


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Evaluation of the Lovell Federal Health Care Center Merger

Findings, Conclusions, and Recommendations



In the late 1990s, health care leaders at the Department of Defense (DoD) and the Department of Veterans Affairs (VA) faced a dilemma in North Chicago: The VA and the U.S. Navy had operated separate medical centers less than two miles apart since 1926. The industry-wide shift to offering patients care in outpatient settings over time left both facilities chronically underused and, in 1999, an internal VA study proposed closing all inpatient care at the VA medical center. VA beneficiaries in North Chicago strongly opposed the closure and gained the support of the Illinois congressional delegation. Meanwhile, the Navy's hospital had become obsolete and needed to be replaced.

The Captain James A. Lovell Federal Health Care Center (FHCC) was the proposed solution. In creating the new joint entity, VA and DoD health care leaders envisioned a state-of-the-art facility that would deliver health care to both DoD and VA beneficiaries from northern Illinois to southern Wisconsin, providing service members and veterans seamless access to an expanded array of medical services. The center, which opened on October 1, 2010, also was expected to showcase new software solutions, enhanced efficiency, and cost savings. Unprecedented for the military and the VA, the Lovell FHCC would integrate clinical and administrative services under a single line of authority.

In 2010, the DoD asked the Institute of Medicine (IOM) to evaluate whether the Lovell FHCC has improved health care access, quality, and cost for the DoD and the VA, compared with operating separate facilities, and to examine whether patients and health care providers are satisfied with joint VA/DoD delivery of health care. The committee outlines its findings in its report, *Evaluation of the Lovell Federal Health Care Center Merger: Findings, Conclusions, and Recommendations*.

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The Promise of Integrating Health Care Centers

In North Chicago, tens of thousands of Navy recruits undergo boot camp training annually at Naval Station Great Lakes, and many enlisted sailors receive advanced training there. Historically, the Navy provided health care to active duty service members and dependents at Naval Hospital Great Lakes, while the VA provided health care to veterans in its own nearby facility, the North Chicago Veterans Affairs Medical Center.

A multistep process of building closures, renovation, and construction paved the way for the Lovell FHCC, which was expected to have a combined VA/DoD medical staff organized in departments and clinics headed by a single chief medical officer, operating under one set of bylaws, and providing one standard of care for all patients.

The Lovell FHCC has been in operation for fewer than two years, and implementation of its integration plan continues. Data on changes in efficiency and cost savings are not readily available. For these reasons, it is too early to tell how successful it has been in delivering at least the same quality health care, or better, at lower cost, without eroding patient and provider satisfaction, the IOM committee writes. The report highlights differences in policies and procedures that must be resolved to enable any joint VA/DoD health care center to deliver integrated and cost-efficient health care and recommends ways the two departments could assist the Lovell FHCC and any future integrated health care organizations in achieving their full potential.

Constraints on Integration

For example, two electronic health record (EHR) systems have to be maintained separately at the Lovell FHCC to allow naval personnel to use other facilities throughout their careers and for veterans to visit other VA medical centers if they move or travel. However, the two independent

systems have limited ability to share patient information, which significantly reduces clinical efficiency. Each department stipulated that neither EHR could be changed. They also relied on the development of software interfaces that would permit the two records systems to work together, which proved too challenging to deliver prior to the Lovell FHCC opening.

Among the new capabilities delivered thus far are single patient registration and sign-on interfaces, orders portability for radiology, and orders portability for the laboratory. But the lack of interoperability requires time-consuming workarounds to keep both records systems current and relies on five full-time pharmacists to manually check for potential drug interactions and allergies to guarantee patient safety—at an added cost of nearly \$1 million per year.

The committee recommends that no new federal health care centers be implemented until an interoperable or joint EHR system is available. Because the software required to enable the two EHR systems to work together smoothly had been so difficult to create, the secretaries of Defense and Veterans Affairs instead committed to developing a new joint system, called the integrated EHR, with final modules due to be completed in 2017. The core set of capabilities required by the Lovell FHCC (and any future integrated facilities) should be completed earlier, rather than later, the committee recommends.

Having different EHRs performing the same function is just one example of the many differences in the policies and procedures of the DoD and the VA that have hampered integrated health care delivery and cost savings at the Lovell FHCC. The IOM committee recommends that the VA and the DoD standardize their policies, procedures, and business practices to overcome differing approaches to handling the same functions. Such standardized solutions could include a unified process for credentialing health care providers, as well as uniform cost accounting, performance and quality measures, drug formularies, and mail-

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order drug refill programs. Congress may need to pass new laws to permit integration of authority, and transfer of employees, funding, and property between departments.

Sharing Lessons Learned

The Lovell FHCC had been planned to be a five-year demonstration of the strengths and limitations of an integrated health care organization, but pressure is building to establish more jointly operated federal health care centers. For this reason, the IOM committee also was asked to determine whether the Lovell FHCC would be a good model for other mergers when the VA and the DoD operate medical facilities in close proximity.

In carrying out the ambitious aim of integrating the functions, policies, procedures, and personnel of two separate health care systems, the leadership of the Lovell FHCC encountered and overcame a number of hurdles. Many resulted from conflicting policies and procedures of the VA, the DoD, and the Navy. Sometimes, they adopted the policy or procedure of one department with the consent of the others. The Navy, for example, relented on its requirement of a secret clearance to access patient records in the DoD electronic system but required a more intensive security investigation than was required for the VA's system. Ultimately, Congress had to enact legislation to authorize the transfer of civilian employees from the DoD to the VA, to transfer Navy-built facilities and related property from the DoD to

the VA, to transfer funds to a joint Department of Treasury account, and to waive co-payments for DoD beneficiaries treated at the Lovell FHCC as they would at a military treatment facility.

Planners of future federal health care centers should not repeat the negotiations that took months and sometimes years to resolve such issues and, instead, should adopt solutions already developed and approved by the VA and the DoD, where they exist. Lovell FHCC staff could make a groundbreaking contribution to future health care mergers if they developed joint VA/DoD guidance materials and a best practices document that explains how they solved problems that emerged during implementation. To that end, the committee recommends that the VA and the DoD systematically compile and analyze the lessons learned at Lovell, including what to do and what not to do, and disseminate that knowledge.

Conclusion

Already, momentum is building to establish additional federal health care centers, driven in part by the desire for a seamless transition from active duty to veteran status of wounded service members returning from the wars in Iraq and Afghanistan. Another driving impetus is the desire to pare health care costs for active duty and retired service members, their dependents, and military veterans. The DoD and the VA look to the Lovell FHCC as a potential response to these concerns.



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The initial implementation of the Lovell FHCC has provided important lessons about how to integrate VA and DoD health care services and has identified remaining obstacles that the departments could overcome to make such mergers more effective and less costly to implement. The Lovell FHCC promises to offer additional lessons in the next three years. Although its staff track certain data, this first national model lacks a comprehensive evaluation plan to objectively judge its success or failure. The VA and the DoD should develop such a comprehensive framework, with measurable criteria, that would provide essential knowledge for both the Lovell FHCC and future endeavors. 

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