

Statement of
Jeannette Chirico-Post, M.D.
Director, VISN 1
Before the
VA CARES Commission
On the
VISN 1 CARES Market Plan Development

August 25, 2003

Mr. Chairman, I am honored to be here to testify before the Commission on the CARES plan for the VA New England Healthcare System (VISN 1). I would like to take this opportunity to introduce the members of the VISN 1 Leadership panel: Mr. Vincent Ng, Director of Providence VAMC and Chair of the VISN CARES Steering Committee; Mr. John H. Sims, Jr., Director of Togus VAMC and Market Team Leader for the Far North Market; Dr. Marc Levenson, Director of Manchester VAMC and Market Team Leader for the North Market; Ms. Karen Waghorn, Associate Director of the VA Connecticut Healthcare System and Market Team Leader for the West Market; and Mr. George Poulin, Associate Director for the Bedford VAMC and Market Team Leader for the East Market.

My testimony outlines the key issues related to CARES planning for VISN 1. Following my remarks, Mr. Vincent Ng will discuss the process the Network used in developing the VISN 1 Plan, followed by remarks from each of the Market Team Leaders on specific issues related to their Markets.

I. VA New England Healthcare System (NEHS-VISN 1)

The VA New England Healthcare System (NEHS) is an integrated health care delivery system that provides comprehensive, high quality, innovative care, in a compassionate manner to all the veterans it serves. The 8900 dedicated employees of this Network provide care and support along a seamless continuum based in primary care supported by eight major medical centers in the six New England states (Maine, New Hampshire, Vermont, Massachusetts, Rhode Island and Connecticut). New England is a large geographic area that covers 70,000 square miles and spans the full spectrum of socioeconomic conditions from dense, urban centers to sparsely populated rural areas. Each of the six states has unique requirements and health care challenges. Thirty- seven Community Based Outpatient Clinics (CBOCs) established throughout New England have improved access to care such that we have health care delivery sites within 30 miles of 97% of the veterans served in New England.

NEHS serves 215,000 veterans with a total budget of over \$ 1.3 billion. Medical centers currently operate 1,915 inpatient beds for acute medical/surgical, mental health, nursing home and domiciliary care. Annually the NEHS has 26,000

admissions and over 2.2 million outpatient visits. NEHS achieved a 30 % market share of Priority 1-3 veterans.

VA New England Healthcare System (NEHS) is committed to providing quality health care and services to the veterans it serves throughout New England. We believe that quality in health care is providing ***“the right care, at the right place, at the right time and at the right cost”*** in order to safely, effectively and compassionately meet the unique needs of each veteran.

The Network approach to health care delivery is through a Service Line structure. Under this model Service Lines have been organized around broad categories: Primary Care, Specialty and Acute Care, Mental Health Care, Spinal Cord Injury, Care and Geriatrics Care, Information Management, Business Office and Local Management. These programs are integrated across the Network to enhance the quality of care by developing consistent standards of care and benchmarks. The model provides for better coordination of care among facilities and better continuity of care for patients. Patients are now able to move among facilities and levels of care more easily. Full implementation of the electronic medical record and telemedicine will further facilitate this process and ensure improved access to patient records for all care providers.

The comprehensive continuum of care offered by the NEHS includes primary care, acute medical and surgical care, psychiatric care, long-term care, nursing

home care and ambulatory surgery. Special programs in NEHS for which VA excels include: Acute and Long-Term Spinal Cord Injury Centers, a Blind Rehabilitation Center, a Radiation Therapy Center, two Domiciliaries, two Cardiac Surgery Centers, MRI, a PET Scanner, Homeless Veterans Outreach Programs, Women Veterans Programs, PTSD National Centers, a Rural Healthcare Initiative, an inpatient Alzheimer's Disease program. Centers of Excellence in VA are clinical programs that exemplify the best of VA care and stand as world-class leaders in their fields. We are proud that many Centers of Excellence are located in our Network, including:

- **Cardiac Surgery:** VA Boston HCS, West Roxbury campus
- **Renal Dialysis:** VA Connecticut HCS, West Haven campus
- **Seriously Mentally III:** VA Connecticut HCS, West Haven campus
- **Seriously Mentally III:** Bedford VAMC
- **Seriously Mentally III:** VA Boston HCS, Brockton campus
- **Women Veterans:** VA Boston HCS
- **Substance Abuse:** VA Boston HCS
- **PTSD:** VA Boston HCS

II. Veteran Population

The NEHS is experiencing both a decline in the veteran population and an increase in the age of those veterans who seek care. Yet even with the veteran population declining, the number of veterans seeking care has increased by 10% in the past year. This scenario presents many challenges because older veterans

typically require more care as well as more expensive care. Expanding home care and community-based programs, and emphasizing health promotion, wellness, and prevention will assist in reducing the cost of care and enable NEHS to treat more veterans. Alternative technological innovations such as Telemedicine programs are being expanded across NEHS. The tele-home care program developed by the Connecticut Healthcare System is a national best practice for providing care such as monitoring of vital signs directly by the veteran in his/her home. This represents a significant enhancement to access, particularly in rural areas where medical services are scarce.

III. Quality and Performance

I am proud that our Network is among the top 3 VISNs on performance measure achievement and is a leader in customer satisfaction results. I believe that with the support of the dedicated 8900 employees in this Network, we will continue to build on these successes.

IV. Fiscal Issues

The Network has been fiscally challenged over the last several years. However, this year we are doing much better financially. Additional allocations were received this year from new VERA changes that went from 3 VERA patient categories to 10 categories. For the first time in the last few years, we have been able to use our capital dollars to purchase needed medical equipment. However,

we will still have financial challenges in meeting the new demand caused by the explosive growth in new patients.

V. Affiliations

Research and Medical Education are key components of the mission of the NEHS. NEHS is fortunate to enjoy meaningful, collaborative affiliations with some of the premier medical schools in the world. These include medical schools at: Harvard University, Yale University, Boston University, Brown University, Dartmouth, Tufts University, University of Connecticut, University of Massachusetts and others. These relationships enhance the quality of care provided by the NEHS facilities and contribute significantly to the education and research missions of the VA. Medical school partnerships assure the best available medical, scientific and educational programs and contribute directly to the provision of high quality care to our veterans. The NEHS is committed to continuing the excellence of the academic and research programs. Many NEHS staff hold faculty appointments at the affiliated medical schools and conduct cutting edge research. NEHS is among the leading VISNs in research funding with the third highest dollar allocation in the Veterans Health Administration (VHA), exceeding \$34.5 million in FY 2002.

The care provided by NEHS is enhanced by its education and research missions and the partnership with prestigious affiliates in medical, dental, nursing, and allied health profession programs. NEHS has over 500 resident positions and

over 400 associate health profession educational agreements for the training of various allied health professions. The academic affiliates and other allied health trainees are, therefore, vital stakeholders in the planning and future direction of NEHS.

VI. Congressional issues

VA NEHS has 35 very active congressional offices, including 12 senators for the six state geographical span of New England. The number of states in VISN 1 is unmatched in any other VISN. Our congressional delegation is a critical partner as we plan improvements to our system. We have worked hard with local, state, and congressional interests to ensure the best for VA, veterans and all stakeholders.

VII. Growth of NEHS

CARES data show clinical programs in VISN 1 being sustained or expanded. However, facilities in VISN 1 have significant infrastructure needs that must be met in order to meet increasing demands. Many infrastructure systems have significant problems which need immediate attention. These infrastructure issues need to be addressed prior to consideration of program expansions indicated in the CARES Planning.

Access to Primary Care is a key part of the VISN 1 plan. The draft National CARES Plan attempts to balance national access guidelines with the current and

future viability of the acute care infrastructure. Because of this, while new access points in this VISN are included in the National Plan, they are not in the high implementation priority category at this time. The other major VISN 1 wide planning principle is the maximum use of telemedicine and home care across the network. Access gaps to Health Care Services and to hospital will be resolved via the addition of a combination of telemedicine technology, expanding existing CBOCs, a new CBOC in Cumberland County, Maine and contracting for services in the community. Telemedicine technology is proposed as a result of our understanding of the needs of a highly rural population, our understanding of the benefits of VA services to this population, and our understanding of the relative scarcity of medical care in many rural areas. Primary Care Providers (PCPs) based at a central location would be the provider “seeing” the patient, with a nurse/mid-level provider at the telemedicine site with the patient. Patient data would be entered into CPRS as is customary with all outpatient visits. Diagnostic imaging studies and laboratory studies will be contracted at the local community hospital. As mentioned earlier, a proposed CBOC for Cumberland County, Maine is not identified in the draft national plan in the high implementation category.

VIII. Proximity Issues

VISN 1 has initiated system improvements prior to CARES. For example, at Manchester, NH: Acute Medicine and Surgery beds at the Manchester, NH facility have been closed. Manchester is currently an outpatient facility.

Newington, CT: Acute Medicine and Surgery beds at the Newington, NH facility have already been closed. Newington is currently an outpatient facility. VISN 1 studied options for sharing of resources among the following five facilities that are within 60 miles of each other: Boston, West Roxbury, Brockton, Bedford and Providence, R.I. One of the major initiatives for VISN 1 is to realign infrastructure with services in the East Market to meet the needs of veterans.

The draft National Plan provides for an evaluation of space utilization at the Jamaica Plain, Bedford and Brockton campuses. VISN 1 will study the feasibility of reallocating space at the Jamaica Plain campus to realize operational savings and to maximize the enhanced use lease potential of the campus for assisted living or other compatible types of use. The multi-disciplinary outpatient clinic will be retained. A study of relocated outpatient services from the Boston Causeway Clinic will be conducted as a part of this evaluation process.

Outpatient services will be maintained at the Bedford campus. Current services in inpatient psychiatry, alzheimer's, domiciliary, nursing home and other workload from the Bedford campus will be transferred to other VISN 1 facilities.

Implementation plans are yet to be developed. However, we would transition over time and in a manner that is least disruptive to patients, and their families.

The remainder of the Bedford campus will be evaluated for alternative uses to benefit veterans such as enhanced use leasing for an assisted living facility. Any

revenues or in kind services will remain in the VISN to invest in services for veterans.

IX. Stakeholder Involvement in CARES

Throughout the CARES process, our Network has been committed to ensuring that all our stakeholder partners have been involved, informed, and provided an opportunity to share their comments about CARES. Over the past year, numerous meetings to discuss CARES were held with stakeholders throughout New England. The Congressional delegation as well as the various stakeholders including employees, volunteers, VSO leadership from six states, Veteran Service Officers, State Commanders, and veterans were involved in the process. Information regarding the CARES process was distributed to the different groups via briefings, forums, and informational mailings. Congressional offices were briefed on CARES during the regularly scheduled quarterly briefings. Employees were briefed on the CARES process during employee forums, which are conducted on a regular basis; through newsletter articles; via electronic messages and updates; and through the distribution of CARES Bulletins.

a. Employees expressed concerns about the potential integration of the Brockton Campus and the Bedford VAMC. Employees were concerned how this would impact their jobs, and the services/programs currently offered to the veterans that utilize the Bedford campus which is located 40 miles away from Brockton.

b. Employees expressed concern regarding the future of the Jamaica Plain Campus and its viability under the CARES process. Concern was also expressed by local Massachusetts Congressional staff with regard to the relocation of outpatient programs from the Causeway Street Clinic located in downtown Boston to the Jamaica Plain Campus when the current lease expires (Clinic) in March 2005.

c. Consideration of contracting versus use of VA staff to provide services—some veterans see contracting as a step toward privatization.

d. Concern that the needs of specific populations such as geriatric and extended care patients were not addressed. It was explained that a detailed analysis of the projected demand and capacity involving VA's long-term care program is being undertaken.

e. Concern as to whether sufficient funding would be allocated for CARES (Indicated that once the Secretary makes his decision about the national CARES Plan in October 2003, funding needs will be determined and funding requests submitted to Congress.)

f. Some veteran leaders in New Hampshire expressed concern about the access to acute hospital and specialty care in New Hampshire. The VISN plan uses the excellent facilities at the White River Junction, Vermont VAMC and other VISN hospitals in conjunction with private contracts with local community facilities to provide acute care.

g. Additional comments received from various service organizations, including members of the Central Mini-MAC and the local Veteran Service Agents in Massachusetts included concerns dealing with access to healthcare, VERA reimbursement, and concerns with the way the process would deal with “gaps”. CARES information has been supplied to the Central Mini-MAC on an ongoing basis as this group meets monthly. Town Hall meetings were held for the veterans at VA BHS, Bedford and Providence. In addition, a briefing was held for State Commander and Town Veteran Service Agents of Massachusetts. Issues of accessibility, continuation of services and potential mission changes were brought forward.

Mr. Chairman, this concludes my statement. Let me say again that I am grateful for this opportunity to address the Commission. I am confident that the process used in VISN 1 to complete our CARES plans was thorough, inclusive and professional. VISN 1 is fortunate to have many talented leaders and dedicated employees who worked to make CARES an important process capable of enhancing the care of veterans in New England for the next 20 years.

I will now be happy to respond to any questions that you or other members of the Commission might have.

**Statement of
Vincent Ng
Director, VA Medical Center, Providence, Rhode Island
Before the
VA CARES Commission
On the
VISN 1 CARES Market Plan Development Process**

August 25, 2003

Mr. Chairman, I am pleased to be here to testify before the Commission on the process used by the VA New England Healthcare System (VISN 1) to conduct CARES planning and the development of the market plan. Dr. Post has outlined the key issues related to CARES planning for VISN 1 and following my remarks, each Market Team Leader will briefly describe issues specific to their market.

The Steering Committee and Market Teams:

As chairperson for the CARES process in VISN 1 my first task was to develop a structure by which our efforts would be coordinated and communicated. To meet that need we established the VISN 1 CARES Steering Committee. The CARES Steering Committee was composed of internal stakeholders from within VA, VBA, NCA, DOD, VA facilities and VISN management. External stakeholders were included and consulted through existing Network structures such as the Management Advisory Council, the Academic Advisory Board and the Labor Relations Council.

The first task of the Steering Committee was to determine our markets. The Steering Committee decided upon the establishment of four markets and that a single team would be used to analyze data and develop plans for each market. Markets were established based on population concentrations, geographic

access and historical referral patterns among existing VISN facilities. The four markets defined for VISN 1 encompass the six New England States. The Far North market encompasses the single state of Maine. The North market includes Vermont and New Hampshire, the East includes Massachusetts from Worcester County east and Rhode Island and the West market includes Connecticut and the western part of Massachusetts.

The market-planning concept improved our ability think in broader terms than those that might result from facility-based planning. The Steering Committee was charged with reviewing and approving market team plans at each step in the CARES process and to make recommendations to the Executive Leadership Council (ELC). The Steering Committee assigned key staff to each market team including a team leader, a planner, a communications coordinator and a VISN service line manager. Other members were then chosen by the market team leader to assist the team based on the unique needs of the individual market. The tasks of the market teams included the analysis of population and workload data, clinical inventory data, data on facility condition codes and the demand projection data generated by the CARES contractor, Condor/Milliman. After review of the population and demand data, a gap analysis using criteria defined by the CARES process was performed in collaboration with VHA-wide teams. Planning initiatives were then developed, prioritized, and referred back to the VISN market teams to develop solutions to meet the gaps. The proposed solutions were briefed to all stakeholders using the established process and after approval, the VISN 1 draft market plan was submitted on April 15, 2003.

Requests for Further information:

Subsequent to the submission of the draft VISN market plan, VISN 1 was asked to provide additional data and clarification in some areas. First, the National Cares Planning Office (NCPO) requested additional clarification on our plans for addressing the proximity planning initiative. We provided a white paper that further described our rationale. Next, we were requested to further justify our

preferred planning initiatives in those areas where the preferred option did not generate the highest rate of return using financial measures such as “net present value” determination. In response to this request, VISN 1 reconsidered some preferred options and put forth our justification for others explaining, where applicable, that other decision criteria other than cost, out-weighed NPV, such as impact on patient access, academic affiliation programs, quality and continuity of care and the impact on research programs. Finally, we were asked by staff from the Office of the Under Secretary for Health to answer specific questions about the feasibility and impact of specific actions related to the Proximity Initiative with a major emphasis on the East market and the metropolitan Boston area. As requested, we prepared a response that described how the proposed actions could be implemented and the full impact based on our best estimates and our collective experiences.

Stakeholder Communications:

A key charge to the Market teams was to include stakeholders in all phases of planning. We were acutely aware of the results of the CARES pilot conduct in VISN 12 and we were determined to ensure comprehensive stakeholder involvement in VISN 1. We sought stakeholder involvement through many mechanisms and at many levels. The market teams made personal contacts with stakeholders on specific planning steps, and they conducted focus groups. The VISN conducted Management Advisory Council (MAC) briefings on CARES and the VISN Communications Office produced VISN-wide CARES bulletins and newsletters. Each VA facility conducted stakeholder meetings, focus groups, open town meetings and disseminated information on CARES. While much of the planning was market-based, stakeholder education and consultation was conducted on many levels.

The CARES planning process was conducted in accordance with a published timeline for the various tasks of the Phase II CARES planning process and it was frequently updated after each step was completed. After each task the VISN

conducted a cycle of review that included the market teams, the steering committee and the ELC. This cycle of review and stakeholder input continued right up to the submission of our draft VISN market plan on April 15, 2003. VISN 1's multiple approaches to communications yielded 800,000 contacts with various stakeholders including 2,000 with Congressional members, 585,000 with veterans and 1,355 direct mailings and emails. These large numbers of stakeholder contacts indicate the scope of our efforts to reach out to all who have an interest in veterans' healthcare in New England.

Conclusion

Mr. Chairman, this concludes my statement. Let me say again that I am grateful for this opportunity to address the Commission. I am confident that the process used in VISN 1 to complete our CARES plans was thorough, inclusive and professional. VISN 1 is fortunate to have many talented leaders and dedicated employees who worked to make CARES an important process capable of enhancing the care of veterans in New England for the next 20 years.

I will be happy to respond to any questions that you or other members of the Commission might have.

Statement of
Marc F. Levenson, M.D.
Director, VA Medical Center, Manchester, New Hampshire
Before the
VA CARES Commission
on the
VISN 1 CARES North Market Planning Initiatives

Mr. Chairman, I appreciate the opportunity to present testimony based on the work that our Market Team has done. The North Market comprises the states of New Hampshire and Vermont. Most of the veterans in these states reside in rural communities. As a result, travel times and distance to VHA treating facilities have been long-standing issues. This has been compounded by the fact that, for several reasons, VAMC Manchester no longer provides acute hospital services on site. While the veteran population of the two states is expected to decline during the planning period (ending FY2022), the number of enrolled veterans is projected to initially increase before declining towards the end of the period. At the same time the age of the average enrollee will increase as will his/her burden of illness. Thus, the total amount of healthcare required by the enrolled population is expected to increase.

The market team developed the following solutions to the planning initiatives

1. Access to Hospital care - currently 57% of enrollees in the North Market meet the CARES criteria for this level of care. The team felt that the most cost-effective method of achieving compliance was for VHA to contract with local non-VA facilities for these services. As this solution is considered, the Commission needs to realize that the level of access to hospital care differs depending on whether the VA procures these services via fee basis or whether VA will be providing these services. The major difference, as far as the impact on veterans is concerned, is that via fee basis regulations, the VA can only pay for acute care services until the veteran is “stable for transfer” regardless of whether a VA bed is available. If the acute care setting were considered a VA site of care, the VA would be responsible for providing services until discharge. In order to make acute care access equitable throughout the VISN, it is recommended that the second alternative be adopted or fee basis regulations be changed.

2. Specialty Care Outpatient - the CARES demand model predicts a large gap in this category. The market plan calls for minor renovations at both VAMC White River Junction and Manchester in order to accommodate this workload. Relating the size of workload increase to available provider capabilities in the private sector suggests it is not feasible to contract this workload to non-VA healthcare personnel. Even with the suggested minor renovations, additional leased space to accommodate the workload may be required.

3. Mental Health Outpatient - the demand model shows a significant gap in this category of care as well. Mental health care for the VA population is required at roughly

twice the rate as in the population at large. As a result, VHA has recognized that Mental Health care should be integrated into each primary care site. The Market Team has followed this guidance in planning to fill this gap.

4. Medicine Inpatient Beds - the preferred solution is to operate an additional 14 beds at the White River Junction facility. Existing space would require minor construction to accommodate these additional beds. With the strong affiliation with Dartmouth Medical School, this additional operating capacity can be brought on line cost-effectively while promoting the educational mission of the VA.

Thank you for the opportunity to testify on behalf of the VISN 1 North Market.

**Statement of
George R. Poulin
Associate Director, VAMC Bedford, Massachusetts
Before the
VA CARES Commission
on the
VISN 1 CARES East Market Planning Initiatives**

August 25, 2003

Mister Chairman, I am pleased to be here today to provide testimony before the CARES Commission on the East Market Planning Initiatives and population trends. The VISN 1 East Market geographically covers all 5 counties in Rhode Island and 10 counties in Eastern Massachusetts and contains a tertiary care facility in West Roxbury, an outpatient facility and hospital in Providence, outpatient and long term care facilities in Bedford and Brockton, an ambulatory care center in Jamaica Plain, outpatient facilities in Boston, Lowell and Worcester and twelve Community Based Outpatient Clinics throughout the Market.

Ninety-six percent of veterans residing in the East Market are within the access guidelines for primary care. Ninety percent of veterans fall under the access guidelines for hospital care and One Hundred percent of veterans in the East Market meet the access guidelines for tertiary care.

In 2001, 117,379 veterans received care at VA medical facilities in the East Market. Population projections show a slight decrease in unique veterans in the next 10 years and a 19

percent decrease in 20 years. Despite the decreasing population, demand for services is projected to increase throughout the planning cycle.

The East Market identified planning initiatives to address outpatient specialty care, primary care, inpatient acute medicine, inpatient psychiatry and inpatient surgery. The proximity planning initiative is part of the Network's proximity planning initiative and was addressed in the Network Director's testimony.

The East Market identified a gap of 216,112 visits in Outpatient Specialty Care. The recommended solutions are to renovate vacant space at all facilities, increase providers, increase hours of operations and contract in the community for the excess demand in both states.

For Primary Care, the East Market identified a gap of 156,310 visits. The preferred solutions are to increase primary care capacity in all existing primary care sites by adding providers, expanding hours of operations and renovating current vacant space.

Workload projections for Inpatient Medicine within the East Market indicate a need to provide an additional 85 beds. Preferred solutions include increasing inpatient medicine beds at West Roxbury and Providence and contracting in the community for the excess demand. The CARES condition assessment supports renovation of both West Roxbury and Providence inpatient space to meet current standards of care.

Workload projections for Inpatient Psychiatry identify the need to reduce 13 beds. The preferred solution includes reduction of beds evenly between Bedford, Brockton and Providence to maintain required services.

Workload projections for Inpatient Surgery identified the need to provide an additional 21 beds. The preferred solution is to contract in the community for this excess demand.

Stakeholders in the East Market were kept informed throughout this process and have generally expressed their support for the East Market solutions. The stakeholders view these solutions as a positive step in meeting the needs of veterans in this market as well as the VISN both now and in the future.

Thank you for the opportunity to testify today on behalf of the VISN 1 East Market stakeholders.

Statement of
Karen Waghorn
Associate Director, VA Connecticut Healthcare System
Before the
VA CARES Commission
on the
VISN 1 CARES West Market Planning Initiatives

August 25, 2003

Mister Chairman, I am pleased to be here today to provide testimony before the CARES Commission on the West Market Planning Initiatives and population trends. The VISN 1 West Market includes Connecticut and Western Massachusetts and contains a tertiary care facility in West Haven, an ambulatory care center in Newington, a long-term care and outpatient facility at Northampton and community-based clinics throughout the Market.

Ninety-six percent of veterans residing in the West Market are within the access guidelines for primary care. Seventy-three percent of veterans fall under the access guidelines for hospital care and all veterans in the West Market meet the access guidelines for tertiary care.

In 2001, 81,000 veterans received care at VA medical facilities in the West Market. Population projections show a slight decrease in unique veterans in the next 10 years and a 25 percent decrease in 20 years. Despite the decreasing population, demand for services is projected to increase in the first seven years of the 20-year-cycle.

The West Market identified planning initiatives to address outpatient specialty care, primary care, and inpatient acute medicine. The West Market is considered in the VISN-wide planning initiative which includes proximity and infrastructure.

The West Market identified gaps of 143,000 visits and 184,000 SF of space in outpatient specialty care. The recommended solutions are to renovate 22,000 SF of space at Newington campus, lease additional space at the Springfield MA clinic, and contract in the community for the excess demand in both states.

For Primary Care, the West Market identified a gap of 86,000 visits and 44,000 square feet. The preferred solutions are to increase primary care capacity in all existing primary care sites by adding providers, consolidating current functions and renovating approximately 11,000 SF of existing space, leasing additional space as necessary, and establishing a presence in the remaining underserved counties in Massachusetts.

Inpatient Medicine within the West Market shows a workload gap of 1,200 bed days of care and a space gap of 35,000 SF at the tertiary facility in Connecticut. Preferred solutions include providing acute medicine at other network facilities, providing 65 inpatient medicine beds in Connecticut, and contracting in the community for excess demand. The CARES condition assessment supports renovation of the West Haven inpatient space to meet current standards of care.

Concerning infrastructure, the West Market, similar to the other Markets in VISN 1, has extensive infrastructure needs, including the research infrastructure.

I would like to bring to your attention to the fact that the VA Regional Office in Hartford is scheduled to co-locate to the Newington campus in 2004. The move will result in savings to the Department of more than \$700,000 in GSA rental costs at the federal building in Hartford while allowing for the occupation of unused space on the Newington campus.

Stakeholders in the West Market were kept informed throughout this process and have generally expressed their support for the West Market solutions. The stakeholders view these solutions as a positive step in meeting the needs of veterans in Connecticut and Western Massachusetts both now and in the future.

Thank you for the opportunity to testify today on behalf of the VISN 1 West Market stakeholders.

Statement of
John H. Sims, Jr.
Director, VA Medical Center, Togus, Maine
Before the
VA CARES Commission
on the
VISN 1 CARES Far North Market Planning Initiatives

August 25, 2003

Mr. Chairman and Commission Members, I am pleased to be here today to provide the Commission with a brief overview of the CARES planning initiatives developed for the Far North Market.

The Far North Market consists of one state and one VA Medical Center. The Togus VA Medical Center is located in south central Maine and serves a veteran population totaling approximately 154,000 veterans in a geographical area that is as large as several other New England states combined. Our healthcare system in this market consists of the Togus medical center, and five Community Based Outpatient Clinics located in Caribou, Calais, Bangor, Rumford, and Saco, Maine. The Togus Medical Center provides a full range of inpatient and outpatient general medical, surgical, mental health, primary care, and geriatric services. Although our market penetration is currently at 24%, it is expected to reach 44% by the year 2012. With our current resources and facilities, only 59% of enrollees have access to Primary Care services within the CARES travel time criteria, and only 52% have access to acute hospital care within the market.

The planning initiatives developed for the Far North market are intended to resolve these access and demand gaps to meet the future needs of our veteran population. Resolution of the access gap for Primary Care Services is planned to be accomplished by increasing VA presence in the rural areas of Houlton, Lincoln, Dover-Foxcroft, Farmington, and South Paris. In addition a new CBOC is planned for Cumberland county. These new locations will also provide enhanced access to mental health services. The demand for outpatient specialty care will be met by using a combination of enhanced space and services at Togus, and the use of private specialists in those specialties that are difficult to recruit such as cardiology. Access and demand for inpatient medical care will be met by adding new beds at Togus, and contracting for beds at private hospitals in selected locations throughout Maine.

Togus was the first facility in the nation designed as a VA Medical Center by the Department of Veterans Affairs in 1866. With full implementation of the initiatives that I have just described, we will continue our tradition of providing our veterans with the quality healthcare services they have enjoyed for 137 years.

Thank you for the opportunity to present this information to the Commission.