

Ben Spadaro

Hudson Valley Veterans Coalition

CARES Commission Hearing

September 17, 2003

Mr. Chairman, Commission members, and interested veterans and citizens:

I feel proud and appreciate the opportunity to provide testimony before the CARES commission today.

I have been actively involved in veterans' issues in the Bronx as well as the Hudson Valley for many years. More recently, I have been involved in the strategic planning process with the VA Hudson Valley Healthcare System.

*to meet quite often with VA people &*

During the past two years, the VSO's have been actively involved in development of the CARES plan. Throughout the CARES process, local VA administration staff continued to involve veterans throughout the community in gaining an understanding of CARES goals. The Hudson Valley Veterans Advisory Committee helped formulate the CARES submittal to the VISN and VA Central Office. There was significant communication with the veterans through meetings and newsletters. I believe it was a well thought out plan and addressed the need for change at both campuses.

Members of the Hudson Valley Coalition reject the revised plan as put forward by Dr. Roswell which changes the operations at Montrose to outpatient only (five days a week) and relocates residential care programs to the Castle Point campus. The Montrose residential program has historically provided high quality services in PTSD, substance abuse and care to homeless veterans. In the initial plan the VAC felt it was important to provide a strong residential care presence in the Montrose geographical area since it provides a central location for those veterans living in the greater metropolitan area. Approximately 50% of Montrose residential patients are from the Hudson Valley area. In addition many come from southern Westchester County and the Bronx. Moving the residential programs to Castle Point would create transportation and other barriers to access for these patients. The result will be decreased access to PTSD, Homeless and Substance Abuse services to the veteran population in Westchester and the Bronx.

We also strongly object the proposal to close the Manhattan VA inpatient programs and for that campus to become outpatient only. That facility provides outstanding specialty care to all veterans in this VISN which includes open heart surgical and neurosurgical care. The elimination of those services would create significant access problems for veterans in the Hudson Valley.

With the changes in delivery of health care and the increasing use of outpatient services and decreasing demand for inpatient bed services, buildings and land at

the Montrose campus became available for other uses. In the late 1990s, even before the development of the CARES process, VA Hudson Valley staff had the foresight to identify an enhanced use lease process to provide new services to veterans. In discussion with many veterans such as myself, a concept was initiated to develop senior independent housing and assisted living for veterans and an idea to create a Life Care community for veterans at the Montrose campus. This was a precursor to veteran involvement in the CARES process and future changes.

In conclusion, I am proud to have worked closely over the years in the planning process for development of new services for veterans in a changing environment. As a part of the continued CARES process, we need to assure that services continue to be accessible to veterans in the communities where they live.

**STATEMENT OF THE  
EASTERN PARALYZED VETERANS ASSOCIATION  
BEFORE THE CARES COMMISSION  
CONCERNING THE CAPITAL ASSET REALIGNMENT  
FOR ENHANCED SERVICES (CARES) MARKET PLAN  
FOR VETERANS INTEGRATED SERVICE NETWORK  
(VISN) 3**

*Submitted by:*

***John D. Del Colle***  
*Associate Executive Director*  
*Eastern Paralyzed Veterans Association*

September 17, 2003

The Eastern Paralyzed Veterans Association appreciates the opportunity to comment on the Department of Veterans Affairs' ongoing Capital Asset Realignment for Enhanced Services (CARES) process and the draft National Plan for Veterans Integrated Service Network (VISN) 3, covering the New York Metropolitan Area, Long Island, New Jersey, and the Hudson Valley. We have worked very closely with VISN3 throughout this process and would like to applaud the VISN for its understanding of both the needs of the Spinal Cord Injury (SCI) population and the opportunity that the CARES process provides to enhance SCI care. Our organization was very happy with the market plan that was submitted by VISN3 to the Under Secretary for Health on which the Draft National Plan is based. We are extremely troubled, however, by several changes made to the market plan by VA Central Office.

**SCI CARE:**

VISN3's market plan called for the elimination of inpatient SCI specialty care at both the Castle Point and East Orange VA Medical Centers with the creation of an SCI out-patient clinic at East Orange. The Draft National Plan, which we are here to discuss today, altered VISN3's market plan by only consolidating Castle Point's SCI services to the Bronx VAMC while leaving East Orange's services intact.

The decision to consolidate Castle Point's SCI services to the Bronx, while regrettable, is long overdue in light of the facility's inability to provide specialty support services. Therefore, assuming that the necessary construction and renovation is properly carried out, we support this relocation of the Castle Point VA Medical Center (VAMC) SCI unit to the Bronx VAMC. We also support the creation of an SCI outpatient clinic at the Castle Point facility, a positive

amendment to the VISN's original market plan made by VA Central Office (VACO), as it will afford the Hudson Valley SCI population an access point for their primary care needs.

As stated earlier, in their market plan submitted to the VA Under-Secretary for Health, VISN3 also proposed the consolidation of all SCI in-patient care from the East Orange VAMC to the Bronx. Subsequent changes were made by VACO to maintain inpatient SCI services at East Orange as a result of VISN 4's failed attempt to produce a comprehensive SCI plan. It is our understanding that East Orange will continue to offer SCI in-patient services until VISN4 resolves its SCI plan.

Eastern Paralyzed Veterans Association supported VISN3's market plan that proposed the transfer of the inpatient SCI unit from East Orange to the Bronx, as we believe that veterans with SCI in VISN3 would be better served if all services were consolidated at the Bronx SCI Center of Excellence. We are disappointed that VISN3's proposal for consolidation has been hindered as a result of VISN 4's lack of planning for SCI care, causing SCI veterans in both VISNs to suffer.

### **Critical Access Hospitals:**

In reviewing the draft national plan and its changes, we discovered a major inconsistency in VISN3's plan. The Draft National Plan calls for the conversion of the Castle Point Facility to a "Critical Access Hospital", a term never before used by the VA. Through the CARES process, the VA intends to adopt the definition of a Critical Access Hospital from the Centers for Medicare and Medicaid Services (CMS), which states that a Critical Access Hospital must be

located more than 35 miles from the nearest hospital, must have no more than 15 acute beds, and cannot have length of stays greater than 96 hours (except respite/hospice). Due to the limited services and relatively short stays, Intensive Care Unit (ICU) beds are discouraged in Critical Access Hospitals.

Eastern Paralyzed Veterans Association is concerned by the apparent discrepancy in the VISN's CARES plan that calls for the transfer of current inpatient and nursing home services, including psychiatric services, from Montrose to the Castle Point Facility. Based on the Critical Access Hospital definition, with its limited acute beds and lengths of stay, the Castle Point facility would not be equipped to effectively treat the population of patients that will be transferred from the Montrose facility. Montrose has historically specialized in psychiatric services and is currently classified as a geropsychiatric facility dedicated to the treatment of elderly persons with mental disorders and advanced dementia. This patient base would certainly require more intensive care than could be offered at a Critical Access Hospital.

When approached with this contradiction, VA Central office dismissed this concern as an implementation problem. The VISN, on the other hand, has claimed that VA will be issuing VA-specific standards for Critical Access Hospitals that differ from CMS'. We feel it is crucial that VA provide clarification of the standards for this type of facility before the adoption and implementation of this recommendation in order to allow for proper planning.

Eastern Paralyzed Veterans Association urges the commission to investigate this issue further to ascertain exactly how, and under what limitations, the Castle Point facility will operate. In

addition, there needs to be clarification as to whether VA will develop their own definition of a Critical Access Hospital or continue to use the definition developed by CMS.

**Possible Closure of Manhattan VAMC:**

Another issue of concern is the draft national plan recommendation to consider the possibility of closing the Manhattan VA Medical Center. This proposal was not contained in the market plan submitted by the VISN but was inserted by VA Central Office. This leads us to believe that someone far removed from the health care needs and market realities facing the veterans in this area decided to contradict the recommendations of the local market planners familiar with VISN3's veteran population and place the possibility of closing this facility on the table.

Anyone familiar with the realities of living in New York City knows that a resident of Manhattan will not leave that borough to access their medical care. Additionally, the public transportation infrastructure does not allow for easy access to the Brooklyn VAMC, the location where most Manhattan Services could eventually end up.

As no actual proposal to close the Manhattan facility has yet been made, Eastern Paralyzed Veterans Association can neither support nor oppose this proposal. Still, the manner in which it came up further underscores our concerns about this process being orchestrated to justify preconceived notions of how the system should look in the future. The CARES data has not driven this final outcome; rather, the desired outcomes have often driven the CARES data.

### **Impact on Mental Health Program:**

Finally, as both the Manhattan and Montrose facilities currently offer psychiatric care it is worth noting that of the 14 facilities slated for closure or discontinuation of in-patient services, 12 have a major psychiatric service component. This targeting of mental health facilities is of particular concern to the Eastern Paralyzed Veterans Association as many of our members are “dual diagnosis” patients who suffer from a variety of mental illnesses as a result of their spinal cord injuries. This is especially appalling as VA has refused to run an official data set for its mental health program through the CARES process and has maintained that this special emphasis program would not be affected. That could not be further from the truth and begs this Commission’s attention.

### **Conclusion:**

Had the Draft National Plan contained the original VISN3 market plan, many of the above - mentioned concerns would not exist. VA Central Office’s insistence on making changes to the market plans belies a fundamental problem with this CARES process. The individual VISNs were tasked with creating a plan, while consulting with stakeholders. VISN3 did an admirable job. Unfortunately, that plan did not meet the preconceived expectations of central office, which resulted in unsound changes. That does not make for quality health care.

We fully intend to continue monitoring the CARES process as it continues so as to ensure that the Special Emphasis programs remain intact throughout the years to come.

**STATEMENT OF  
PAUL A. WEKENMANN  
SUPERVISOR NATIONAL SERVICE OFFICER  
OF THE  
DISABLED AMERICAN VETERANS  
BEFORE THE  
CAPITAL ASSETS REALIGNMENT FOR ENHANCED SERVICES COMMISSION  
BRONX, NEW YORK  
SEPTEMBER 17, 2003**

Mr. Chairman and Members of the Commission:

On behalf of the local members of the Disabled American Veterans (DAV) and its Auxiliary, we are pleased to express our views on the proposed Capital Assets Realignment for Enhanced Services (CARES) Market Plans for this area in VISN 3.

Since its founding more than 80 years ago, the DAV has been dedicated to a single purpose: building better lives for America's disabled veterans and their families. Preservation of the integrity of the Department of Veterans Affairs (VA) health care system is of the utmost importance to the DAV and our members.

One of VA's primary missions is the provision of health care to our nation's sick and disabled veterans. VA's Veterans Health Administration (VHA) is the nation's largest direct provider of health care services, with 4,800 significant buildings. The quality of VA care is equivalent to, or better than, care in any private or public health care system. VA provides specialized health care services—blind rehabilitation, spinal cord injury care, posttraumatic stress disorder treatment, and prosthetic services—that are unmatched in the private sector. Moreover, VHA has been cited as the nation's leader in tracking and minimizing medical errors.

As part of the CARES process, VA facilities are being evaluated to ensure VA delivers more care to more veterans in places where veterans need it most. DAV is looking to CARES to provide a framework for the VA health care system that can meet the needs of sick and disabled veterans now and into the future. On a national level, DAV firmly believes that realignment of capital assets is critical to the long-term health and viability of the entire VA system. We do not believe that restructuring is inherently detrimental to the VA health care system. However, we have been carefully monitoring the process and are dedicated to ensuring the needs of special disability groups are addressed and remain a priority throughout the CARES process. As CARES has moved forward, we have continually emphasized that all specialized disability programs and services for spinal cord injury, mental health, prosthetics, and blind rehabilitation should be maintained at current levels as required by law. Additionally, we will remain vigilant and press VA to focus on the most important element in the process, enhancement of services and timely delivery of high quality health care to our nation's sick and disabled veterans.

Furthermore, local DAV members are aware of the proposed CARES Market Plans and what the proposed changes would mean for the community and the surrounding area. As you are aware, the hospitals serving America's veterans here in the New York City area are serviced by

an extensive public mass transit service. Any consolidation or relocation of services from one facility to another may on the surface appear to be a cost-saving measure, when indeed it is a disservice to the veterans who rely on services from the affected facility. For example, the plan to relocate services from the Manhattan 23rd Street VA Medical Center (VAMC) to the Brooklyn VAMC has just made it so a veteran who by way of mass transit to the 23rd Street facility, now has to take two trains and two buses, and this now equates to an hour and a half commute. I have not seen in the draft National CARES plan where an allotment or consideration has been taken on how veterans who utilize services at these local hospitals will be affected by way of removal of services or relocation. In some respects, the consolidation of services will cut off access for a segment of the veteran population who cannot overcome the burden imposed by the relocation of services. More consideration needs to be given to the relocation of inpatient services from 23rd Street to the Brooklyn facility. As is well known, a patient's recovery is aided by the support he or she would receive from family. Consequently, relocation of services for inpatient care would diminish family access to the recovering veteran.

The 23rd Street facility currently serves 32,000 veterans on an inpatient basis per year and serves an extraordinary number of veterans on an outpatient basis. To consolidate inpatient services to Brooklyn would eliminate veterans who seek care at the 23rd Street location by virtue of locality. Moreover, The 23rd Street facility has had teaching/intern contracts with medical schools in the location, specifically the New York University School of Medicine and Bellevue Hospital. These schools have aided the 23rd Street facility in becoming specialists in the area of neurosurgery, cardiac surgery and urology. Nowhere in the draft National CARES Plan recommendations do I see an attempt to accommodate these valuable services or maintain the continuity of the relationship with the schools. More specifically, the 23<sup>rd</sup> Street facility is noted to be a center of excellence for AIDS and HIV care, with a significant focus on research. Currently, there are six projects being funded totaling 1.1 million dollars. Patients who are active in the research are also enrolled with the medical school affiliates. The 23rd Street facility is also recognized as the benchmark institution for AIDS and HIV care by the VA AIDS and HIV collaborative center based in Palo Alto, California.

With respect to "maintaining significant outpatient primary and specialty care presence in Manhattan at the current site or another appropriate location in Manhattan" needs to be defined with specifics, as to what significant outpatient services and what specialty care services will be provided. The decision to dismantle and fragment services at the 23rd Street location is ambiguous and has too many variables. The exorbitant amount of veterans who rely on services and care at that facility need to have a clear vision of where and what services will be available. Currently, more than 100,000 veterans are waiting six months or more for an appointment at VA medical facilities. Closing and consolidating services can have no positive impact on this. The shareholders and veterans need to know how this proposed relocation and consolidation of services will improve timely access to already delayed care.

The DAV certainly supports any fiscally responsible adjustment to services so long as the change accommodates those veterans who are currently utilizing services. To DAV, any cost cutting measure that undermines the delivery of services and accessibility to sick and disabled veterans is considered fiscally irresponsible and unacceptable. Sick and disabled veterans are products of our government's desires and need coupled with the veterans will to meet the

demand. Any regression in services destabilizes the Governments responsibility to care for those it has placed in harms way.

In closing, the local DAV members of VISN 3 sincerely appreciate the CARES Commission for holding this hearing and for its interest in our concerns. We deeply value the advocacy of this Commission on behalf of America's service-connected disabled veterans and their families. Thank you for the opportunity to present our views on these important proposals.

## New York State Division of Veterans' Affairs Statement on CARES Commission Plan

The proposed closing of the United States Department of Veterans Affairs facilities in New York has galvanized the State's veterans community, which feels betrayed by the VA -- an institution it has embraced and supported over the decades as it provided vital health and mental health services to untold numbers of veterans.

The New York State Division of Veterans' Affairs appreciates the challenge the Commission faces in developing a long-range national plan to meet the health care needs of our veterans well into the twenty-first century and understands that any proposal is bound to generate a negative reaction somewhere.

While the Division empathizes with the VA's struggles to create a comprehensive -- and acceptable -- national plan to better use its resources, we strongly urge the Commission to fully consider the impact any facility closure will have on accessible health services for veterans, employment opportunities for staff and the fiscal effect on the surrounding community.

The Division of Veterans' Affairs' primary concern is that veterans now served at those targeted facilities continue to receive and have access to health care they need and deserve. Transferring health services to other VA facilities may disenfranchise those veterans unable to relocate or to access on a regular basis a distant facility.

Reutilization of space on the Canandaigua campus, the Montrose Campus or the Manhattan Campus should be addressed, but simply closing facilities as a cost-cutting measure does not improve access or care for veterans, and must not be the driving force of a comprehensive plan for the future of veterans' health care.

The Division also is concerned with the employment opportunities of the hundreds of VA workers, particularly in rural Ontario County, whose careers and jobs would be at risk by the closing. And, just as troubling is the economic impact such a dramatic undertaking will have on the many local businesses that provide goods and services to the medical centers.

The Division urges the Commission to consider these concerns, and to forestall any action until these issues are fully and publicly addressed to assure veterans and their families that any action taken will produce improved quality of care and accessibility for services within the veterans community.



**BENJAMIN S. WEISBROTH**  
Deputy Director

**NEW YORK STATE**  
Division of Veterans' Affairs

c/o VA Regional Office  
245 W. Houston Street  
Room 206  
New York, NY 10014  
Phone: (212) 807-3162  
Fax: (212) 807-4021

e-mail: [bweisbroth@veterans.state.ny.us](mailto:bweisbroth@veterans.state.ny.us)  
website: [www.veterans.state.ny.us](http://www.veterans.state.ny.us)



# The American Legion

DEPARTMENT OF NEW YORK  
112 State Street \* Suite 400 \* Albany, New York 12207

**STATEMENT OF  
R. MICHAEL SUTER, CHAIRMAN  
VETERANS AFFAIRS & REHABILITATION  
DEPARTMENT OF NEW YORK  
THE AMERICAN LEGION  
BEFORE THE  
CAPITAL ASSET REALIGNMENT FOR ENHANCED SERVICES  
(CARES) COMMISSION  
ON  
THE NATIONAL CARES PLAN  
SEPTEMBER 17, 2003**

Mr. Chairman and Members of the Commission:

Thank you for the opportunity today to express the local views of The American Legion on the Department of Veterans Affairs' (VA)'s Capital Asset Realignment for Enhanced Services (CARES) initiative as it concerns Veterans Integrated Services Network (VISN) 3. As a veteran and stakeholder, I am honored to be here today.

## **The CARES Process**

The VA health care system was designed and built at a time when inpatient care was the primary focus and long inpatient stays were common. New methods of medical treatment and the shifting of the veteran population geographically meant that VA's medical system was not providing care as efficiently as possible, and medical services were not always easily accessible for many veterans. About 10 years ago, VA began to shift from the traditional hospital based system to a more outpatient-based system of care. With that shift occurring over the years, VA's infrastructure utilization and maintenance was not keeping pace. Subsequently, a 1999 Government Accounting Office (GAO) report found that VA spent

approximately \$1 million a day on underused or vacant space. GAO recommended, and VA agreed, that these funds could be better spent on improving the delivery of services and treating more veterans in more locations.

In response to the GAO report, VA developed a process to address changes in both the population of veterans and their medical needs and decide the best way to meet those needs. CARES was initiated in October 2000. The pilot program was completed in VISN 12 in June 2001 with the remaining 20 VISN assessments being accomplished in Phase II.

The timeline for Phase II has always been compressed, not allowing sufficient time for the VISNs and the National CARES Planning Office (NCPO) to develop, analyze and recommend sound Market Plan options and planning initiatives on the scale required by the magnitude of the CARES initiative. Initially, the expectation was to have the VISNs submit completed market plans and initiatives by November, 2002, leaving only five months to conduct a comprehensive assessment of all remaining VISNs and develop recommendations. In reality, the Market Plans were submitted in April 2003. Even with the adjustment in the timeline by four months, the Undersecretary for Health found it necessary in June 2003, to send back the plans of several VISNs in order for them to reassess and develop alternate strategies to further consolidate and compress health care services.

The CARES process was designed to take a comprehensive look at veterans' health care needs and services. However, because of problems with the model in projecting long-term care and mental health care needs into the future, specifically 2012 and 2022, these very important health care services were omitted from the CARES planning. The American Legion has been assured that these services will be addressed in the next "phase" of CARES. However, that does not negate the fact that a comprehensive look cannot possibly be accomplished when you are missing two very important pieces of the process.

The American Legion is aware of the fact that the CARES process will not just end, rather, it is expected to continue into the future with periodic checks and balances to ensure plans are evaluated as needed and changes are incorporated to maintain balance and fairness throughout the health care system. Once the final recommendations have been approved, the implementation and integration of those recommendations will occur.

Some of the issues that warrant The American Legion's concern and those that we plan to follow closely include:

? Prioritization of the hundreds of construction projects proposed in the Market Plans. Currently, no plan has been developed to accomplish this very important task.

? Adequate funding for the implementation of the CARES recommendations.

? Follow-up on progress to fairly evaluate demand for services in 2012 and 2022 regarding long-term care, mental health, and domiciliary care.

### **VISN 3 – VA New York/New Jersey Veterans Healthcare Network**

VISN 3 serves a wide diversity of needs for the greater New York City and New Jersey veteran population. Having already addressed the New Jersey Market Area with the CARES Commission previously, the testimony given here today will focus on the remaining New York Market Areas of VISN 3.

#### **Long Island Market Area**

This market area encompasses all of Long Island and is served by one VA medical center, Northport; three community based outpatient clinics; and six mental health clinics. The Draft National CARES plan proposes to continue existing healthcare and expand outpatient services. The current baseline reflects over 100,000 veterans of the 215,000 veterans in the market area are currently receiving primary care. Outpatient primary and specialty care requirements need to be increased based on demand data reflecting an 80 percent increase by the year 2012 and remaining 30 percent above the initial 2001 baseline in 2022. During local CARES meetings in the past, VA officials have stated that if a specific area wanted a CBOC all they had to do would be to donate the space. The American Legion adamantly disagrees with this type of bargaining for healthcare. The VA should identify large pockets of veteran populations in this market area and open CBOC's accordingly.

#### **Metro New York Market Area**

This market area is sub-divided into three smaller market areas: VA Hudson Valley Healthcare System, New York Harbor Healthcare System, and the Bronx VA medical center.

**VA Hudson Valley Healthcare System.** This sub-market area includes two VA medical centers: Montrose and Castle Point. The draft CARES plan transfers current services of domiciliary beds and all other inpatient units including

psychiatry, medicine and nursing home beds, and research activities from the Montrose campus to the Castle Point campus. The Montrose campus will maintain

outpatient services at a site that will maximize the enhanced use lease potential of the campus. The Castle Point campus will retain its currently provided services; primary care, acute care, and long term (nursing home) care and absorb those services transferred from the Montrose campus. Castle Point will transfer its Spinal Cord Injury and Disorders (SCI/D) unit to the Bronx VA medical center while maintaining an SCI outpatient unit. Castle Point will convert to a Critical Access Hospital (CAH).

There is a 77 percent projected increase in primary care workload by 2012 based on the 2001-workload data. The requirement for psychiatry inpatient beds will grow by 11 percent by 2012 and then decrease to the 2001 base line figure by 2022. Transferring this capability to Castle Point will require new construction before the transfer of services.

The American Legion opposes the transformation of Montrose from a medical center to only an outpatient primary care center at this time. The IBM data indicates a marked need for increased primary care services through 2012 in this sub-market and a slight increase through 2012 for inpatient psychiatry beds. Expansion of primary care at both campuses and retention of all other services at each campus will ensure adequate coverage for our veterans. The expansion of space requirements at Castle Point is questionable given the minimal space available for the expansion. The continuation of existing acute medical inpatient beds at both locations will further support DoD backup missions. If the need arises to support the DoD during times of armed conflict the availability of medical beds will allow the VA Hudson Valley Healthcare System to provide backup facilities to other VA medical centers who may receive casualties from the theater of operations.

The assignment of the Castle Point medical center as a Critical Access Hospital (CAH) facility similar to the Medicare program designation seems a little premature. Support for a new system requires policy guidance, criteria development, and performance expectations, none of which have been determined or approved.

The American Legion has been assured that the CARES process will not just end; rather, it is expected to continue into the future with periodic checks and balances

to ensure plans are evaluated as needed and changes are incorporated to maintain balance and fairness throughout the healthcare system.

**New York Harbor Healthcare System (NYHHCS).** This sub-market area includes the New York VA medical center, Brooklyn VA medical center, and St. Albans campus. The current CARES plan would have the inpatient care at the New York (Manhattan) medical center consolidated at the Brooklyn campus. Manhattan would maintain a significant outpatient primary and specialty care presence at the current site or another appropriate site. St. Albans would demolish all existing buildings and build new facilities for outpatient care and nursing home and domiciliary care.

The need for new construction at the St. Albans campus for primary, nursing home and domiciliary care is justified and warranted. Plans for the new construction should include the construction of a new facility to provide primary and specialty care services to accommodate the projected outpatient needs in the Queens area. The care of veterans should not be interrupted during this construction and transition.

The Manhattan medical center provides acute care (ER, ICU, medical, surgical and psychiatric) services. Specialization includes invasive cardiology, cardiac surgery and neurosurgical care. The Brooklyn medical center provides acute care services and specializes in radiation oncology, inpatient and outpatient cancer chemotherapy and palliative care. Both campuses have adequate vacant space available for inpatient bed expansion. Facilities are easily converted (i.e. re-activation of wards) to accommodate the predicted growth through the 2012 period. Just as easily, the wards can be decommissioned if the need arises.

The draft cares plan indirectly affects Research in terms of the healthcare systems ability to maintain an active teaching and research environment. By maintaining adequate medical beds at all three locations, the ability to attract and retain high quality staff will support an environment that promotes education and research.

The American Legion opposes the closing of any VA medical center at this time given the anticipated growth in primary, acute, specialty, and nursing home care throughout the 2012 period. Further, changes in eligibility for all veterans could very well cause increases through the 2022 period. The simple appearance to quietly suggest that the Manhattan campus transfer all inpatient services to Brooklyn and the maintain outpatient services at the Manhattan site or some other appropriate site smacks directly in the face of any veteran receiving healthcare at

the Manhattan medical center as a polite under the table way of saying “close down that facility”.

**Bronx VA medical center.** This medical center provides acute care services and specializes in SCI, oncologic care, and is the referral center for the Hudson Valley Healthcare tertiary care. The draft CARES plan calls for the Metro New York Market Area’s SCI/D inpatient care to be centralized at the Bronx campus.

I would like to leave you with the following veterans comments. CARES facility data supports short term (5–10 years) increases in inpatient beds. Population density in this Market Area suggests as more veterans retire and lose private health insurance; VA will be relied upon heavily. Do not close beds until reevaluation of needs in 2012. VA should consider access needs for patients, given significant transportation issues in this Market Area. CBOC’s work well and act as a method to attract new enrollments. The contracting out of medical care will lead to a weakening of veterans identifying with VA.

Finally, The American Legion is concerned about funding. CARES is a very expensive undertaking. There is no mention of a priority plan to accomplish the proposed construction and renovation. Many of these projects are years away from fruition. Given the current budget climate, and knowing the history of VA funding, the likelihood of adequate funding to implement these proposals is not very high.

Again, I appreciate the opportunity to appear before you today.