

Testimony of James B. Page, MD, JD, MPH

I am Dr. James B. Page, currently Associate Dean for Clinical Affairs, and Assistant Clinical Professor of Medical Education and Public Health at the University of Wyoming. I have a long association, both personal and professional, with the VA health care system. Many of my family members have received care through the system, and I personally have used the Grand Junction VA. I have trained in the Denver VA system during my medical school years, and in the Palo Alto and Menlo Park, California facilities during my residency at Stanford. My medical training includes an internship in internal medicine at Kaiser Santa Clara, a psychiatry residency at Stanford, an MPH at Berkeley, and training in occupational and environmental medicine at UCSF. I have participated in the CARES process as a representative of the University of Wyoming. Prior to my medical training, I was an officer in the Army Corps of Engineers and subsequently worked as an industrial engineer, financial analyst, and corporate planner for several Fortune 500 companies, including ARCo, Exxon and Mobil. I am thus familiar with both the merits and demerits of large scale planning exercises, such as the CARES process. I commend those who have participated in the CARES process for their diligence and persistence. I am, however, concerned about several aspects of the process itself, and the resulting draft document.

As an engineer and planner, I am well aware that planning process outcomes are highly dependent on the input and assumptions used during the process. In the case of the CARES process, it was apparent from the outset that an underlying assumption was that centralization, consolidation, and increased volume were desirable outcomes. This was especially apparent in the use of relatively large minimum numbers that had to be met before an area of increased need was considered valid, regardless of the percentage increases involved. It was also apparent in the small facilities initiative, which presumed smaller facilities to be inherently less efficient and of lower quality. The effect of these assumptions has been to significantly penalize those programs that provide services to rural areas. This is particularly regrettable, given that rural areas have historically provided this nation with a disproportionate share of its military personnel.

This effect is compounded by other aspects of rural health delivery, particularly in the intermountain west. Over the past year, I have spent a great deal of my time attempting to understand rural health issues, and to develop a sense of rural health needs. These efforts have led me to the following conclusions regarding future rural health needs, which do not appear to have been considered adequately in the planning process.

These include the following:

The population of Wyoming and several other western states is aging rapidly, both due to aging in place, and to the in migration of substantial numbers of retirees, including military retirees, who are attracted to the state's lifestyle and uncrowded terrain.

Wyoming's health care providers are also aging, which, combined with already low numbers of providers (Wyoming is 47/50 in number of physicians per capita), and a relatively high median age, will result in loss of over ½ of our physician workforce in the next 10 to 15 years. It remains to be seen how many of these physicians the state will be successful in replacing.

There has been a rapid decline in interest in primary care medicine training, which has traditionally provided the bulk of the rural physician workforce.

Medical malpractice costs are escalating rapidly, placing further pressure on physicians in the state.

Medicare reimbursements, already lower in the rural west than in many other areas of the country, appear likely to continue to lag costs of providing care, resulting in fewer physicians who will accept new medicare patients.

These factors are likely to increase the number of veterans seeking care from the VA system above that predicted by the models used in the plan, due to lack of availability of care from alternative sources.

A further concern that I have as a physician is the proposal to convert smaller VA hospitals to Critical Access Hospital look-alikes. The Critical Access Hospital program has been a life saver to small rural communities attempting to maintain adequate access to acute health care. However, its merits lie largely in allowing these facilities a better avenue for coping with the Medicare and Medicaid reimbursement systems. As the draft report acknowledges, there is little evidence that following that model in the VA system is likely to enhance either quality of care or produce cost efficiencies. It will certainly decrease patient convenience and reduce available social supports if needed care must be obtained at larger facilities several hours away. There is substantial research supporting the premise that availability of social supports and quality of relationship with treating physicians are more predictive of positive outcomes than any other aspects of the treatment interaction. Thus care provided close to home at a smaller facility by familiar care providers with nearby social support may produce better outcomes than technologically superior care at a distant facility by unfamiliar care providers.

I am also concerned about elimination of ICU's from the smaller hospitals. Based on my experience during my medical training, I question the assumption that one can adequately pre-select patients for admission and thereby insure that no complications requiring intensive care will ensue. Many of my ICU patients during training were there for reasons no-one could have predicted in advance, including vomiting with aspiration after minor surgery, complications of a biopsy, an unexpected GI bleed in a floor patient, and a rib

fracture with a punctured lung after a patient fell. One of my most vivid memories from my internship was a week when I admitted a 93 year old woman with congestive heart failure who was delirious with urosepsis, who went home after 3 days of IV antibiotics and gentle IV hydration, and a 43 year old otherwise healthy woman admitted for bronchitis with exacerbation of her asthma, who developed a pneumonia and died after a week in the ICU. A study in progress at Kaiser during my training was attempting to develop a predictive algorithm for ICU length of stay and outcomes. The preliminary results showed no useful a priori predictive measures, with the major part of the variability in outcomes dependent only on events occurring after ICU admissions. I would be very reluctant to admit a patient to a hospital that did not have the ability to ensure quick transfer to an adequate ICU in the event of unexpected changes in their condition.

My final concern is that of a medical educator. The University of Wyoming operates two family practice programs that are focused on training physicians to practice in rural Wyoming and other rural states. The Cheyenne VA has been a vital partner in providing that training for the Cheyenne residency. We rely on the VA to provide a substantial part of our training in Internal Medicine, in particular the care of older, relatively sick and complex patients. One of our challenges in maintaining accreditation is providing sufficient internal medicine training to our residents. The proposed changes in the mission of the Cheyenne VA would seriously damage our training program, and could potentially threaten our accreditation.

In conclusion, I would urge those responsible for further work on the CARES process to revisit their recommendations for rural areas and small facilities in light of the special problems of rural areas like Wyoming. In particular, I would recommend that one of the several rural health research entities, such as RUPRI, be retained to review the report in order to contribute their substantial expertise in rural health care delivery.

My experience in industrial engineering has taught me that bigger is not always better, and that distributed systems often are more reliable and provide better outcomes, in many cases at competitive costs. There are diminishing returns to increased scale, and there is a large literature regarding economy of scale in full retreat, wherein larger operations are in fact often less efficient than smaller ones. Before taking actions that will harm access and convenience in our rural area, it is vital that the gains anticipated from those actions be based in reality, not merely in theory.

Thank you very much for the opportunity to testify in this important matter.

James B. Page, MD, JD, MPH

STATEMENT OF
KYNDRA K. MILLER, WYOMING STATE PLANNING COORDINATOR
GOVERNOR FREUDENTHAL'S STAFF, WYOMING
REGARDING DRAFT NATIONAL CARES PLAN

23 October 2003

Mr. Chairman and members of the Commission:

Thank you for the opportunity to testify concerning the draft national CARES plan. I am the Wyoming State Planning Coordinator, and work on Governor Freudenthal's staff. The Governor requested that I testify regarding this important matter that is of great concern to the Governor, and citizens, of Wyoming.

I am a former active duty Army JAG Captain. In fact, this time last year I was in the middle of my deployment in support of the Global War on Terrorism. I know, firsthand, what service members endure in an operational setting; and how good it feels to finally return home after being deployed for months on end. There's no prouder moment in a soldier's life than returning from deployment, touching down on American soil and knowing that you answered your country's call and served honorably.

I also know, first-hand, the value of services provided by the VA to our veterans. While in the JAG Corps I served at Walter Reed Army Medical Center and represented countless soldiers in their disability boards. I cannot articulate the relief expressed by many soldiers when they learned that the VA would be there for a lifetime; and would provide on-going care that the Army could not.

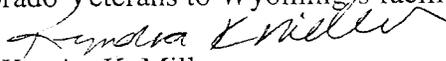
Having served on active duty, and having had the unique opportunity of representing disabled soldiers, I appreciate, and value the services offered by the VA. Wyoming Veterans simply cannot afford to lose valuable services that are now offered through the Cheyenne, VA Medical Center. Traveling to Denver is not a sufficient answer to the problem on several fronts.

It is important to underscore that many veterans who will be traveling to Denver will not originate in Cheyenne, but could originate from the farthest corners of our vast state. Therefore, the additional travel time from Cheyenne to Denver adds another unnecessary leg, to an already long trip. Furthermore, Wyoming's harsh winters and road closures could lead to dangerous delays of important medical treatment, particularly when trying to reschedule a medical procedure at Denver's facility which is large, has a heavy patient load, and a presumably tight schedule. While we understand the interest in consolidating services; it shouldn't be done at the expense of critically ill veterans who need timely care.

Wyoming's VA hospital is different than other small facilities around the United States because of our growing retiree population. The AARP predicted that by 2020 Wyoming will have the highest percentage of residents over 65 in the nation; and Kiplinger's Magazine has already ranked Wyoming as "the best place in the United States to retire." Therefore, as our older population increases, so too will our veteran population. In fact, the CARES study (table 8.1) demonstrates that Wyoming's projected need for beds remains strong and consistent; while it declines in most other small states by as much as 75%. Therefore, given Wyoming's current and future utilization of the VA facility, contrasted to other small facilities, it makes sense to keep Wyoming's VA fully operational.

The Governor feels very strongly that the Wyoming VA should continue to offer the whole menu of services currently offered to our Veterans. He also recognizes the purpose of this Commission, to consolidate and streamline care. Therefore we would like to present an alternative. Instead of requiring Wyoming Veterans to travel to Denver for care, we invite the VA to invest in Wyoming's facility and bring more of the Denver/Front Range market to Wyoming for treatment. It is more accessible, less congested, travelers would drive against the flow of traffic, lodging and restaurant accommodations are more affordable, there is room for expansion, and the facility would still be small enough to continue its record of outstanding care. In fact many Colorado Veterans already chose to the Cheyenne VA over the Denver VA, for many of these reasons.

We are proud, and grateful for the wonderful services offered by the VA, and stand ready to cooperate with VA officials on every level to keep Wyoming's facility fully operational. Exporting care to Denver is a mistake, and veterans would suffer. As a former Army Officer, we went above and beyond to "take care of soldiers." In that spirit, the VA should take care of Wyoming's veterans by leaving our facility fully operational; and considering, instead, bringing more Colorado Veterans to Wyoming's facility.


Kyndra K. Miller
Wyoming State Planning Coordinator

Paul Hawway Sr

Northern Arapaho Business Council

P.O. Box 396

Ft. Washakie, Wyoming 82514

Phone 332-6120 — 332-5006 — 307-856-3461



POSITION PAPER OF THE NORTHERN ARAPAHO TRIBE ON REDUCING SERVICES AT THE CHEYENNE VAMC

October 23, 2003

Good afternoon Mr. Chairman,

My name is Burton Hutchinson, Sr.; I am an enrolled member of the Northern Arapaho Tribe, located on the Wind River Indian reservation. I also am the Chairman of the Northern Arapaho Business Council. I am here today to make some comments about the possible closure of inpatient surgical services the Cheyenne VAMC provides.

There are presently 7,448 enrolled Arapaho members residing on the Wind River reservation and approximately 532 veterans are enrolled in our Northern Arapaho Veteran's Assistance Program (NAVAP). This is 7 % of the total population. However, the NAVAP is in the process of identifying more veterans and that total will be more. There is an outpatient VA clinic in Riverton that serves veterans but for reasons unexplainable our Arapaho veterans are not utilizing these medical services as expected. The NAVAP and the Riverton Outpatient clinic are working together to have our Arapaho veterans take advantage of these services.

Historically, our Arapaho veterans have been going to the Cheyenne VA for their medical needs and are comfortable with this process and this has been the trend since WWII, Korea, Vietnam and our other recent conflicts. Whenever Arapaho veterans were scheduled for a medical visit to the Cheyenne VAMC, the Northern Arapaho tribe assisted that veteran with transportation. The visits may have been for general outpatient or for major surgeries but the veteran was able to travel 296 miles to Cheyenne to make that appointment. Presently, we do what we can to assist veterans needing to get to the Cheyenne VAMC. During the winter months these trips were especially hard on the veteran. Wyoming winters can be pretty harsh.

Our Northern Arapaho veterans are now older. Our Vietnam veterans are in the 50+ ranges, our Korean veterans are in the 70+ range and our WWII veterans are in the 80+ range. It is difficult for our veterans to travel to Cheyenne for health care and if we were asked to travel an additional 104 miles to Denver, it would add to the difficulty. The other closest major VA facility would be the Salt Lake VAMC, 314 miles from the Wind River reservation. The other VA facility in the state is Sheridan but there are no surgical services available. Again, travel in the winter months would add to the burden. It should be noted that many Arapaho veterans prefer to go to the Cheyenne VAMC because of the quality customer service; it is a smaller facility and very user friendly. In the larger urban areas, our veterans tend to be intimidated by these surroundings. Most of our older veterans need someone to drive them because of their disabilities and this poses a problem for housing of that transporter in the event the veteran's needs to spend a few days at the medical center.

As the Chairman for the Northern Arapaho people, I am aware of the changes in the operating environment in the future for Indian health care. There will be more growth and shifts in the Indian service population, the escalation of health care costs, limited federal dollars, changes in policies and procedures relative to reimbursement of health care services, new Congressional authorities and new Indian health laws. Just recently the Veteran's Administration and the Indian Health Service signed a Memorandum of Understanding. What direct impact will this MOU have on sovereign American Indian governments?

I share these observations with you because it is important for people who do the cross-cutting initiatives know how grass roots American Indian people are impacted by these implementations, especially our American Indian veterans. The experiences I have had as a tribal chairman with budget reductions, once the cutting starts, it never seems to stop. Not only are our Indian veterans impacted but all veterans share in the loss of veteran's benefits. Who speaks for those other brave veterans who know and paid the price of freedom? Those that served in the United States military performed an invaluable service to our beloved country and it is only fair our country express gratitude for those services by ensuring the availability of benefits and medical services.

The staff at the Cheyenne VAMC is to be commended on their acceptance of cultural sensitivity to health issues facing American Indians. Dr. Kilpatrick, Cheyenne VAMC Director and Joseph Pugliese, Director for Business Development Service Line made it possible for the National Indian Veteran's Ninth Annual Summit to be held here at the Cheyenne VAMC in August, 2002. During that summit we erected three teepee lodges and three ceremonial sweat lodges and conducted sacred Arapaho ceremonies on campus. Because of this, the Arapaho people feel that our relationship with the Cheyenne VA is strengthened. In November of 1998 I was asked to do a prayer service and blessing of the Cheyenne VAMC and it was a great honor for me to do this. Those intentions I prayed for have been fulfilled; however, there is more benefit for the Cheyenne VAMC and those courageous veterans it serves.

Also during that time there was a one day conference for Indian Veterans to discuss how accelerated services can be made available to American Indian veterans who suffer from substance abuse, diabetes and PTSD. The tribes represented were the Blackfeet, Crow, Grosventre, Assinboine/Sioux, Salish/Kootenia, Northern Cheyenne, and Chippewa/Cree from Montana. The Northern Arapaho and Eastern Shoshone from Wyoming were also there along with the Sioux tribes from North and South Dakota. A plan was developed that will enhance the level of care Indian veterans receive in the area of substance abuse, diabetes and substance abuse.

Mr. Chairman, I am a combat veteran who served in Korea. I served with the Second Infantry Division, Ninth Regimental Combat Team, and Company E. In my particular outfit, I served as a scout and received the Combat Infantry Man's Badge and the Bronze Star. I also am a traditional healer and leader in all our ceremonial lodges. I have served on our Arapaho Business Council intermittently since the early sixties. A great deal of public life has been serving my Arapaho people. I love my Arapaho people from the youngest, even the unborn, to the eldest. I work for my people so that our generations will speak the language and live our Arapaho way of life for a long, long time. What I say to you today is true and from my heart.

Our Arapaho people have great respect and honor for those who put on the uniform of the United States military. We have special ceremonies for those warriors who have served our country and our Indian way of life. Whenever there is a call to arms Arapaho men will answer, to not only protect our American way of life but to protect the way of the Arapaho; indeed, Indian way of life. I encourage you, the committee, to be like the Arapaho and show the respect and honor due all veterans by leaving intact those medical services that will serve all veterans.

Thank you, and God Bless all of us.

Burton Hutchinson, Sr., Chairman
Northern Arapaho Business Council