

P.V.A.

CARES Commission Denver, Colorado (9/22/03)

Members of the Commission, the Mountain States Chapter of the Paralyzed Veterans of America (PVA) is pleased to provide its input to you regarding VA's plan for the future delivery of medical services to veterans with spinal cord injury or disease (SCI/D) during this phase of VA's Capital Asset Realignment for Enhanced Services (CARES) initiative. PVA recognizes the vital importance of the CARES process. VA's CARES initiative is designed to meet the future health care needs of America's veterans by charting a course to enhance VA health care services through the year 2022.

For PVA members, there is no alternative health care delivery system in existence that can deliver the complex medical services required to meet the on-going health care needs of veterans living with spinal cord injury or disease. For us, VA's spinal cord injury centers are a matter of life or death, a matter of health or illness, and a matter of independence and productivity. Additionally, PVA is pleased to see that VA's recent CARES document understands the need to assure the availability of neurosurgical medical services at all SCI Center locations.

Following World War II, the life expectancy of a veteran with a spinal cord injury was just over one year, but now because of important medical breakthroughs, many achieved through VA medical research, and the development of VA's network of spinal cord injury centers a veteran with a spinal cord injury can expect to live a fairly normal lifespan. However, during our lifetimes we depend, time and again, on the VA SCI center system to meet and resolve the health care crises we encounter as we grow older.

Our local PVA Chapter has been seriously involved with the CARES process since its inception, we attended local CARES meetings, and we provided our comments on the VA's VISN Market Plans affecting our area to our national office who in turn provided them to you. On the whole, the Mountain States Chapter feels relieved that VA's SCI population and workload demand projections model recognizes the need for increased VA SCI acute and long-term care medical services through fiscal year 2022. VA's VISN Market Plans call for the addition of four new SCI centers located in VISN 2, 16, 19 and 23 and for additional long-term care beds in VISN's 1, 8, 9 and 22. These new centers and long-term care beds are essential to meet the growing medical needs of PVA members across America and in our local area.

VISN 19 MOUNTAIN STATES CHAPTER

The Mountain States Chapter of PVA supports the construction of a new 30-bed SCI center in Denver, Colorado. We have been advocating for the construction of this much needed SCI center for years and it has universal local support. PVA also supports the addition of SCI long-term care beds at the nursing home care unit but insists that these beds be staffed with SCI trained physicians and nurses.

PVA is pleased to see that VA's recent CARES document continues to support the original VISN 19 Market Plan report for a new 30-bed SCI Center located in Denver. However, we are concerned that the document does not mention the addition of SCI long-term care beds at the nursing home unit. The much needed SCI long-term care beds are supported by the VA's SCI projection model and PVA.

We also feel that VA must make every effort to plan for and meet the growing demand for long-term SCI care in our area. For us, long-term care means a mix of services such as: hospital based home care, on-going home visits for medical equipment and accessibility evaluations, respite care, assisted living, and SCI nursing home long-term care.

Finally, the Mountain States Chapter must speak about the importance of intra-VISN coordination and collaboration if VA's CARES SCI plan is to be a success. VA's SCI center system has evolved into a highly efficient hub and spoke system. Each VA VISN must understand and abide by VA's SCI Handbook 1176.1. In our area, our members may choose to receive medical services from a variety of VA SCI providers that best meets their SCI medical needs. This is their right. It is vital that VA's SCI referral protocols be respected by each VISN so that individual SCI veterans can receive care in the most appropriate setting according to their choice and medical need.

While we are pleased with the commissions' proposal for a new hospital for Denver, we however remain concerned about the proposed reclassification for the Grand Junction and the Cheyenne Wyoming VAMC.

Both of these hospitals continue to provide high quality efficient health care to an every growing veteran population.

The VAMC in Wyoming in addition to meeting the health care needs to the Wyoming veteran population also treat a high number of veteran's from North Eastern Colorado.

I might add that North Eastern Colorado is severely limited in the number of health care services available.

Grand Junction is unique in that it provides service to the entire western slope of Colorado waiting time to be seen with both of these hospitals or days compared to months at the Denver VAMC.

Additionally, Grand Junction and Cheyenne have not had any trouble attracting or keeping trained nurses.

Bottom line is that in reclassifying of both facilities will place an additional burden on the Denver VAMC.

We ask that you reconsider your proposal for both Grand Junction and the Wyoming VAMC.

Once again the Mountain States Chapter stands ready to assist the Commission in understanding the unique SCI medical care needs in our geographical area. If we can be of further assistance please don't hesitate to contact the Mountain States Chapter Mark Shepard, Executive Director, 1101 Syracuse Street, Denver, CO 80817 at 303-322-4402 or Bill Conroy, NSO III at 303-914-5590.

Thank you for listening to our concerns.

Statement of the Veterans of Foreign Wars,
Department of Wyoming
to the Commission on Capital Asset Realignment for Enhanced
Services (CARES),

September 22, 2003 in Denver, Colorado

Mr. Chairman and members of the CARES Commission: I am pleased to discuss our input to the market plans and the impact of the planning on the Cheyenne, Wyoming VA Medical Center specifically. Our organization devoted a great deal of effort working on and coordinating our state's market plans. While doing so, we continually focused on VA's long term planning mission which is: "to improve access, quality, and cost effectiveness of veteran's health care."

We agree that VA must properly address the issue of their unused and under-utilized facilities. Tough choices must be made.

However, unused or under-utilized VA facilities are not a significant concern in Wyoming. What is significant is the need to improve access to health care. The nature of our mountainous terrain, severe weather conditions, long travel distances, and sparse population, most residents live in small communities or on farms and ranches, mandates a flexible approach to the delivery of basic goods and services provided within the region. This flexibility includes planning for the effective delivery of VA health care in our rural and frontier areas. Our residents accept the rigors and challenges of living in the Rocky Mountain west. In return, VA must recognize the unique lifestyle and tailor delivery of services to the region accordingly.

To meet the need for improved VA access in rural Wyoming, Dr. Maffet has proposed two additional community outpatient clinics in Wyoming, located in Rawlins and Afton, and another for northern Colorado, to be located in Sterling. Depending on local

circumstances, purchasing health care locally by VA should be considered as possibly the best option in smaller, geographically remote communities. In any event, we strongly support Dr. Maffet's initiative for additional access points as critical to the well-being of the veterans living in rural areas.

As Doctor Maffet has testified, the draft National CARES plan recommends that the Cheyenne VA Medical Center retain acute medical beds and convert to a Critical Access Hospital model. Furthermore, a future review of the Center's in-patient surgery program and utilization of ICU beds is scheduled.

The Cheyenne VA Medical Center provides very high quality health care services designed to meet the needs of southern Wyoming, western Nebraska, and northern Colorado veterans, we believe, in the most efficient manner. Convincing program reviews have determined that transferring surgical services to

another VA hospital would create a market gap and a contract with the community hospital would not be cost effective, with no guarantee of measurable improvement in quality over VA services now being provided in-house.

The staff of the Cheyenne VA Medical Center is known for doing an excellent job, the quality of care provided is undeniably high. In fact, Cheyenne's performance indicators meet or exceed the VA's national goals in many important categories.

Cheyenne VA Medical Center's management, actively working with representatives from veterans service organizations and other stakeholders, developed recommendations put forth in their market plan only after scrutinizing the data gleaned from several program reviews. Cheyenne management has rightfully concluded that transferring or contracting inpatient services are the two least desirable options considered. However, it seems to us

that local recommendations were disregarded and revised by the national CARES planning staff without benefit of supporting data. Since these recommendations are now incorporated into the draft National CARES Plan, we believe the integrity of the entire CARES process may be in question.

The VFW is not willing to accept a draft national plan containing proposals that increases costs, inconveniences veterans and their families, with no apparent increases in quality of care; and neither should the taxpayers who will be burdened with paying for the increased costs.

It is well known, all things being equal, that veterans prefer to receive their care in a local VA facility; an earned benefit provided as one of America's promises in return for the sacrifices of faithful military service. In our view, the Cheyenne facility is appropriately sized and appropriately located to meet the primary

and secondary medical needs of the veterans living in the smaller communities, farms, and ranches scattered throughout the region.

It makes no sense either, for the VA to transfer services to the Denver VA Medical Center, 100 additional miles south. We believe patients, veterans or non-veterans alike, should be treated as close to their homes as possible. There are many reasons why transferring inpatient services out of Cheyenne is not in the best interests of veterans and their families. Of course, the inconvenience of additional travel distances for aging and ailing veterans and their families, combined with increased transportation, food and lodging expenses, along with the demands of severe weather conditions are major concerns. Delays in obtaining routine services such as MRIs and heart catherizations from larger VA facilities are common due to patient backlogs. Veterans can pay several thousand dollars for out of pocket medical expenses for non-VA services when VA care is not readily

available or when urgently needed. If any costs savings are gained by transferring services, the savings are minimal when compared to the concerns.

The success story of the Cheyenne VA Medical Center should continue un-encumbered by the CARES process. The VA Medical Center has no vacant or underused buildings so capital asset re-alignment is not required. But, veterans require improved access to primary and secondary care throughout Wyoming, western Nebraska, and northern Colorado.

We are confident that a positive outcome of the CARES process is the Commission's recognition of the need to work towards achieving the VA's goal of improving veteran's access, particularly when considering the unique requirements of veterans living in our rural and frontier areas. We recommend two ways of doing this, additional primary care outpatient clinics in the rural

communities, as Dr. Maffet has proposed. We ask that the Commission favorably consider these out patient clinics for Rawlins, Afton, and Sterling, Colorado as a means for veterans to access VA primary care as close to their homes as possible. We also ask for favorable consideration for retaining, even expanding, inpatient surgical services at the Cheyenne VA Medical Center. We believe these are best options, each designed to meet the existing and future primary care and secondary care needs of Wyoming's and the region's veterans in the most cost-effective and efficient manner without placing greater hardships on the veteran.

Thank you for the opportunity to address this hearing.

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**STATEMENT OF
GOVERNOR OF WYOMING
WYOMING MILITARY DEPARTMENT
STATE OF WYOMING VETERANS' COMMISSION
BEFORE THE
CAPITAL ASSET REALIGNMENT FOR ENHANCED SERVICES
(CARES) COMMISSION ON
THE DRAFT NATIONAL CARES PLAN
SEPTEMBER 22, 2003**

Introduction—Don Ewing, State Director/Joseph Sestak, Commissioner

Madam Chairman and members of the CARES Commission, it is an honor to meet with you here today. I come to testify as the State of Wyoming Veterans' Commission and on behalf of Dave Freudenthal, Governor of Wyoming and Maj. General Wright, the TAG. Our Commission is statutorily charged to evaluate current and potential veteran issues and make recommendations to the legislature and the Governor. We represent all 57,550 Wyoming veterans, 45,000 of who do not belong to any service organization – these 57,000+ veterans compose more than 10% of our state's population, and 34% of our veterans use the VA system.

In the recent Draft National CARES Plan, it is recommended that surgery and ICU services currently provided by the Cheyenne VAMC be transferred to the Denver VAMC or contracted out. In the VISIN 19 plan submitted to the planning office earlier, this was the least acceptable option. Wyoming still views this as the least acceptable option. Contracting for some or all of these services in Wyoming is not likely to save money in either the short or long run. Our Doctors and Surgeons, all top level and practicing in a medically underserved climate, can name their own price in most markets as they already have established client pools that keeps their services in demand.

From our constituency, we are constantly reminded that in the Cheyenne VAMC, we have one of the most outstanding VA Medical Centers in existence. It is clean, well run, efficient and has very high patient satisfaction. To give you an idea of this satisfaction, at a meeting at the hospital between our State Director and Dr. Maffet, on Aug. 29th, 2003, (immediately following an IG inspection) it was stated that the IG had canvassed 31 patients and received 31 positive responses. To Governor Dave Freudenthal and the

veterans of Wyoming, this is no surprise – it is the type of service we have come to expect and receive at our Cheyenne VAMC.

Transferring inpatient surgery services to Denver or Contract would be a terrible blow for the hospital as well as the veterans of Wyoming. Our Wyoming veteran population continues to grow and the patient visits at Cheyenne continue to increase (some at 100's of percent over 5 years)– we expect over 13,000 patient visits this year. This growth remains true even with some “unique VA accounting practices” such as dropping the Category 8 veterans from the population model! In short, we are seeing an increased demand across the state and at the Cheyenne VA hospital.

I am concerned that the needs of veterans in rural communities are being disregarded to achieve minor or mythical financial savings. Wyoming's rural status should not be used to reduce the quality and timeliness of care of veterans that live in this state. This option only makes sense to someone in Washington, DC, not to the veterans that live in Wyoming. Moving inpatient services to Denver increases driving distances and travel time for our older and disabled veterans.

Another component is the fact that F.E. Warren Air Base, located in Cheyenne, utilizes the VA hospital for many of its more difficult procedures and diagnosis. With our active duty, guard and reserve service members shouldering an ever-increasing role as a result of 9-11, do we want to compromise our fighting forces by forcing them to travel to Denver, taking them out of their community, for a procedure that can be done as well or better and at a lower cost in Cheyenne? Any reduction of surgical services at the Cheyenne VAMC will eliminate surgical/ICU medical services to F.E. Warren Air Base (DoD), TriCare and ChampVA patients. All base surgical/ICU is sent to the Cheyenne VAMC. Additionally, as the Cheyenne VAMC is a training site for University of Wyoming medical procedures and nurses, reduction in services would exacerbate Wyoming's already medically underserved status.

The Draft CARES plan would close down a major portion of a fine hospital today, for a hospital at Denver at some future date – at least years away. It is akin to giving up a bird in hand for two in a far away bush that we may never see – at least not for 4-8 years! And in the meantime, during all these years, we increase the patient load at Denver, which is already overloaded. This is a bad deal for Wyoming.

The Cheyenne surgical program produces excellent outcomes as shown by National Surgical Quality Improvement Program data and the Cheyenne VAMC has recently added a much-needed orthopedic program. If the VA is truly interested in quality medical care for Wyoming's veterans, they will not reduce the services offered at the Cheyenne VAMC.

The Cheyenne VAMC is highly competitive and efficient, and in the end provides the best access to Wyoming veterans in the most cost efficient manner.

Don't misinterpret what I just said, I support a new hospital in Denver, but I do not support any reduction in services or staff at our Cheyenne VA hospital.

Wyoming by its very nature is a frontier state. From a single office window in Washington DC, one can view a population that exceeds the entire population of Wyoming – our state spans 276 mile N/S and 375 miles E/W and encompasses several major mountain ranges and their accompanying high altitude passes. As a result, many veterans are already required to travel hundreds of miles to the Cheyenne VA Hospital, and this travel can be hazardous, if not impossible as these mountain passes are subject to blizzards 9 months of the year. The short 45-mile drive from Laramie to Cheyenne in good weather takes approx. 1 hour. It can take up to 5 hours and when Interstate 80 closes, you cannot make it at all – and this is with a modern 4-wheel drive! By way of example, this scenario played out for my wife and me on May 17&18th of this year. She was driving back to Laramie from SLC and I was coming back to Laramie from Cheyenne. The interstate was closed intermittently due to a heavy, blowing snow, and it took me over 4 hours to drive my 45 miles. It took my wife over 4 hours to travel the 100 miles from Rawlins to Laramie. The drive from other towns and rural areas are often even worse. This situation can happen anytime from mid-Sept. to late May. In the event that our veterans were required to drive on to Denver, you can see that they may have already driven for 8 or more hours, and then they have to drive the additional 120 miles to the Denver hospital. Many times Denver and the surrounding area experiences severe weather such as the late October '97 snowstorm that dumped 2 to 3 feet of heavy snow on Denver and essentially shut down the city for 2-3 days. In short, we have hazardous winter driving condition in the mountains and valleys of Wyoming and there are often hazardous winter driving conditions on the way to Denver. Both states have somewhat frequent interstate highway closures due to severe weather, which already affects our Wyoming veterans.

The transfer of care from the Cheyenne VAMC to the Denver VAMC places great and unnecessary physical and financial burdens on veterans and their families. Finally, current facilities in Denver are incapable of absorbing an influx of Wyoming veterans. If improved access is a goal of the CARES commission, this draft proposal fails Wyoming veterans. This plan does nothing more than cause greater hardship for our Wyoming veterans.

In addition to the often severe winter weather in our very rural state, we need to factor in our aging veterans. As with most states, our veteran's average age is getting older every year. Again using the example of an older vet that has already driven through ice and snow to get to Cheyenne, then has to drive another 120 miles on roads covered with ice or snow, you have the recipe for disaster – by the time the veteran gets to Denver he/she is tired and when they hit that traffic snarl in bad weather, they just have difficulty coping. Older veterans' reactions are compromised and we become prime candidates for an accident. Wyoming cannot support a plan that jeopardizes our Wyoming veterans in such a callous manner.

Dave Freudenthal, Governor of Wyoming, the TAG, Maj. General Wright and this State Commission want to make it abundantly clear that we do not want to see any reduction of services at Cheyenne. We place great faith that our Congressional delegation to work

tirelessly to insure retention of all service at our fine Cheyenne VA Medical Center. We encourage the CARES Commission to reach a solution that retains all existing services at the Cheyenne VAMC.

In summary, Wyoming needs and deserves a VA hospital in Cheyenne. We have one – the Cheyenne VAMC, and it is a very good one. Please go back and do the right thing and support us in keeping our Cheyenne VA hospital open at it's present or expanded level. There is an old axiom that has stood the test of time well, it is: If it ain't broken, don't fix it. The Cheyenne VA Hospital is not broken, so please don't fix it.

Thank you for your time. Governor Dave Freudenthal, Maj. General Wright and I humbly request that you to make a decision that retains all current services at the Cheyenne VAMC – this option is in the best interest of all Wyoming's veterans.

**STATEMENT OF
ROBERT E. LOUGEE
NATIONAL SERVICE OFFICER
OF THE
DISABLED AMERICAN VETERANS
BEFORE THE
CAPITAL ASSETS REALIGNMENT FOR ENHANCED SERVICES COMMISSION
DENVER, COLORADO
SEPTEMBER 22, 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 Realignment for Enhanced Services (CARES) Market Plans for this area in VISN 19.

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 the 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, Colorado DAV members are aware of the proposed CARES Market Plans and what the proposed changes would mean for veterans in the community and the surrounding area. We are also cognizant of the fact that allocated resources will ultimately determine what facilities and services will be realized.

DAV members in the state of Colorado are opposed to any action by VA Central Office that would downsize existing VA Medical Centers (VAMCs) or reduce the level of services currently being provided by these facilities. In fact, we embrace the VISN 19 Market Plan as it proposes the addition of facilities and services to handle the increase in demand for more timely medical care without compromising quality.

We fully support the proposed scenario of building a free standing VA Medical Center at the Fitzsimons complex. Based upon structural, health and cost concerns surrounding the outdated Denver VAMC, we believe it would be advantageous for the American taxpayer if VA and the Department of Defense (DOD) would enter into a joint venture agreement. We feel that this would be a win-win situation for both VA and DOD but most importantly, for the veterans in the state of Colorado. A new facility at Fitzsimons would equate to easier access to health care for veterans, updated medical equipment and technologies and foster a mutually advantageous relationship between the University of Colorado Medical Center and the VA.

We oppose the National CARES Plan proposal concerning rural health care issues. The VISN 19 plan called for 7 Community-Based Outpatient Clinics (CBOCs); however, the National CARES Plan proposes no new clinics for VISN 19. We are concerned that the standard established by VA Central Office for placement of CBOCs does not take into account the geographical challenges encountered in the VISN 19 area. For instance, 5,000 veteran enrollees are the standard within a certain number of counties in a geographical area to warrant placement of a CBOC across the country. We feel this standard should be adjusted as the veteran populations for each VISN differ greatly. Counties on the East and West coast have dense veteran populations whereas counties in the Mid-West and Northwest have a veteran population that is spread out over larger geographical areas. CBOCs in VISN 19 and across the country are advantageous to veterans, as travel distances are reduced, saving time and resources, while at the same time providing much needed preventive medical treatment.

Our review and comparison of the VISN 19 CARES Plan and the National CARES Plan Executive Summary indicates a lack of specifics in the National CARES Executive Summary. This leads us to believe that proper attention and consideration of the VISN 19 CARES Plan were not undertaken by the producers of the document.

Colorado DAV members understand that this is a complex issue and that tough decisions will have to be made. As stakeholders in this undertaking, we are prepared to be a part of the solution and not the problem as long as the best interest of veterans and the integrity of the process are protected.

In closing, Colorado DAV members of VISN 19 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.



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Michael O. Leavitt
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Sept 22, 2003

Cares Commission Testimony

Thank you for the opportunity to present remarks concerning the CARES process as it relates to Utah.

In the interest of time and to allow ample time for other presentations I have purposely kept my remarks brief and to the point.

In Utah, I was one of the participants in the CARES process for the VA Salt Lake City Health Care System. I was impressed by the thoroughness and willingness to accept input by CARES members VA SLC HCS. I helped facilitate and coordinate town hall meetings around the State of Utah.

One initial concern I had and still want to underscore is that of population variances reflected by the VA's population estimating tool and census 2000. Utah had one of the highest percentages of variation in veterans population numbers. According to census 2000, Utah had 161,000 veterans. Vet Pop showed approximately 35,000 less veterans. This is a fairly significant number, especially for a state the size of Utah. Southern Utah is one of the areas with significant veteran population variation.

X |

Pop. Variation
Issue of
Small Numbers

I support the recommendations of the VA SLCHCS relative to the process for Utah.

It is my hope that one of the by products of this process is to reduce the substantial wait time for veterans at VA SLCHCS.. I receive more complaints from veterans, the Governors office, and Congressional Offices on this issue than any other.

My final comment is to ask the commission to insure that to the degree possible that political pressure not be allowed to bend the process to allow CBOC's or other facilities to be placed in locations that do not meet the criteria that has been established . In order for the process to work and have credibility it must be objective and be based on strong empirical data.

Terry Schow
Director

“PUTTING VETERANS' FIRST”

**STATEMENT OF
TODD WHITE, NATIONAL VICE COMMANDER
THE AMERICAN LEGION
BEFORE THE
CAPITAL ASSET REALIGNMENT FOR ENHANCED SERVICES
(CARES) COMMISSION
ON
THE DRAFT NATIONAL CARES PLAN
SEPTEMBER 22, 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) 19. 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 at veterans health care 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 19 – WESTERN ROCKIES, GRAND JUNCTION, EASTERN ROCKIES

These three markets encompass the states of Colorado, Utah, the southeast and sections of Wyoming, and parts of Idaho, Nebraska and Nevada. The VA medical facilities that service these areas are located in Salt lake City, UT, Denver, CO, Cheyenne, WY and Grand Junction, CO.

Access

Through the CARES process, all three markets were identified as having hospital care gaps. The DNP proposes to increase access for hospital care by contracting at seven sites throughout VISN 19. Similarly, tertiary care gaps existing in the Eastern Rockies Market will also be met by contracting for care.

The American Legion wonders where all these sites are located? While we understand that in some instances it may be necessary to contract out, we believe this measure should be used as a last resort, only after all of the other avenues have been exhausted. We have many concerns about the contracting of care on such a wide scale not the least of which are the ability of the community to provide the expertise needed and the communities willingness to contract with VA. Other concerns include continuity of care for the veteran and the increased chances of records being lost by being shuffled back and forth between facilities. With the increase in contracted care as proposed in this plan, VA may experience degradation in their ability to provide the expertise they are so well known and respected for. Finally, VA is a provider of care and not a purchaser of care.

Small Facility

The DNP recommends the conversion of Grand Junction and Cheyenne facilities into Critical Access Hospitals (CAHs). Cheyenne, for the near future, will retain its acute beds, but will transfer some inpatient services to Denver or contract out. The American Legion is pleased to see that the facility will remain open, albeit under the designation of a CAH. The concept of CAHs originated with the Centers for Medicare and Medicaid Services (CMS) to address that particular agencies rural health care shortage. VA borrowed the idea but has yet to publish guidelines on what exactly a functioning CAH is. For now, they are using CMS criteria.

Concerning Cheyenne, the proposal to *transfer some inpatient services to Denver or contract out* clearly indicates the lack of a plan. The American Legion opposes the transferring of services to Denver. There is a considerable distance between Cheyenne and Denver that veterans would be forced to travel. A two-hour drive in good weather can quickly change to a much longer and more hazardous drive during the winter months. Additionally, the VISN has already evaluated the option of contracting out or transferring some services and their conclusion was to keep the acute beds. They cited several reasons for this:

- ? High marks for the Cheyenne medical center by external reviewers.
- ? Volume and case mix are sufficient to continue inpatient care.
- ? Volumes at other VA medical centers are expected to increase.
- ? Quality performance is high.
- ? The majority of the physicians are board certified.
- ? The inpatient service is cost efficient as shown by data indicating lower unit costs than local Medicare or TRICARE rates.

The American Legion recommends that Cheyenne maintain the services and care it currently provides. We also believe there is no reason to change the mission, restrict the mission (by designating it a CAH) or study the feasibility of transferring services or further contracting out of services. It is an excellent facility that provides much needed services to the veterans in Wyoming, Western Nebraska and Northern Colorado. Further the Cheyenne facility currently has Department of Defense (DoD) agreements to provide services for active duty military stationed at the Francis E. Warren Air Base.

Grand Junction, like Cheyenne, is an excellent facility and it provides care to 38,000 veterans in a 17 county area in western Colorado and eastern Utah. It maintains high performance scores, has little problem recruiting and attaining specialty doctors, the turn over in nursing is low, and inpatient services are cost efficient and lower than Medicare for surgery and medicine. The American Legion recommends that Grand Junction maintain the services and care it currently provides. Like Cheyenne, there is no reason to make any changes at this hospital or to initiate any feasibility studies regarding closing of services.

Outpatient Services

The DNP proposes many options regarding the increased need for primary care and specialty care services. These options include construction, renovation and contracting of care during high peak periods. Even though the DNP did not include the establishment of any new Community Based Outpatient Clinics (CBOCs), The American Legion believes VA should reevaluate the need for them within VISN #19. Again we feel that contracting these services should only be a last resort after all other internal options have been evaluated and every effort should be made to staff the CBOCs with VA personnel.

Inpatient Services

The DNP proposes to build a replacement hospital on the Fitzsimmons campus. This has been the plan for quite some time given the fact that the current Denver facility is over 50 years old and is undersized for its mission. Its support systems are inadequate for modern health care and it is reaching a non-recovery condition. The American Legion supports the building of a new structure. We believe this move would help facilitate sharing with the Department of Defense (DoD) and continue the affiliation with the University of Colorado, an affiliation that has proven to be very valuable to VA and in turn to the veterans in the local community of Denver.

Extended Care

The American Legion supports building a nursing home on the Fitzsimmons campus. The current proposal is to build it next to the State Veterans Nursing Home on the campus.

Enhanced Use

The Western Rockies Market, serviced by the Salt Lake City Health Care System, is in the discussion stages with a developer and the University of Utah. The plan is to build a new facility that could accommodate the consolidation of research between VA and the University and house all the researchers in one location.

The American Legion does not oppose enhanced use (EU) leasing provided VA and the veteran benefit from the arrangement. We would also note that the EU process is fairly long, sometimes taking three or four years to complete a project. The American Legion would like to see that process streamlined and the timeline cut in half. It would be much easier for VA to negotiate a lease if the decision process were shortened.

Special Populations

The DNP proposes to build a 30-bed Spinal Cord Injury Center to be located at the replacement facility in Denver. The American Legion does supports this proposal.

Thank you for inviting the comments of The American Legion on this very important issue. I will be happy to answer any questions you may have.