

Stakeholder Issues

AMVETS, as a stakeholder of the USDVA, is also very concerned with some of the issues presented by the VISNs in the Stakeholder Issues Summary. We will address the key issues by VISN.

VISN 1:

There appears to be four schools of thought about what CARES will and won't do. The first school is that of VHA management personnel, who appear to have a very good grasp of the concept. The second school is that of the Stakeholders themselves. These men and women are concerned that they will lose access to the health care that keeps many of them alive today. The third and fourth groups are the employees and unions, who appear to be more concerned with the loss of jobs than with the change in health care. The third and fourth groups need to be reminded that the VHA is for the veteran, not for the employee or the union.

We feel that, as explained in the summary, management has adequately assuaged the fears of the veteran community. However, we still have concerns. The VISN is located in New England which includes areas that have some fairly severe winters. We are concerned with driving time from home to medical facility for older veterans with diminished vision, hearing, and reflexes. In the depths of winter, a veteran over age 65 who's driving over 30 minutes to receive health care is at risk of an automobile accident every minute of the trip. This could be a minor incident such as sliding off the road to an accident involving serious injuries or death. For this reason, we would like to see VHA, either itself or through the use of Veteran Service Organizations, State Departments of Veteran Affairs, or County Veteran Service Officers, utilize a van or bus service to transport veterans to medical facilities.

VHA is going to close some facilities, that's understood. They may increase the services at other facilities, open CBOCs, or utilize contracted health care to replace these closures. Some employees will be RIF'd, others will be transferred, and others will be offered early retirement. That, too, is a given. Our primary concerns here are two fold. Access to health care for the veteran, whether urban, sub-urban, or rural, must be maintained. If Reductions in Force are required we would request that military veterans employed by the VHA be retained in all cases.

Contracted care, if required, brings out a few additional concerns. Is the vision considering contracting for primary care, specialty care, or the entire spectrum of care? If the entire spectrum of care is under consideration, we have concerns about VA specific programs such as PTSD, SCI, Agent Orange, Atomic Veterans, Undiagnosed Illnesses, Prosthetics and Blinded Veterans to name a few. We also have concerns about continuity of care, record keeping and reporting, and billing issues. Would contracted physicians be skilled or trained in the medical areas of concern? Would their staffs be skilled or trained in the administrative areas of concern? What would be expected of the contracted physician in relation to claims for compensation with the VBA and with C&P Exams?

The final area of concern addressed by the VISN is one of Academic Affiliates. We believe that's an in-house issue and are not concerned with the issue.

VISN 2:

The primary concerns addressed for VISN 2 were the same as VISN 1, with possibly more emphasis on Stakeholder Concerns about access. Readdressing these issues would be redundant.

VISN 3:

The primary concerns addressed for VISN 3 were the same as VISN 1, with possibly more emphasis on Stakeholder Concerns about access. Readdressing these issues would be redundant.

VISN 4:

The only area of concern in VISN 4 appears to be in the Western Market and is related to VAMC Pittsburgh. AMVETS supports full funding for the proposed construction and consolidation at this location.

VISN 5:

The primary concerns addressed for VISN 5 were the same as VISN 1, with possibly more emphasis on Stakeholder Concerns about access. Readdressing these issues would be redundant.

VISN 6:

All primary concerns in VISN 6 appear to have been satisfactorily addressed.

VISN 7:

We find it disheartening that the VISN reports minimum Stakeholder input into the CARES process. Having been involved with CARES from the beginning (VISN 12) and being aware of the significant input in other VISNs, it may very well be that Town Hall meetings, VSO meetings, and other, similar, forms of contact were improperly formulated. We feel that the VISN should, again, solicit Stakeholder input. Perhaps attending meetings of the various VSO chapters/posts in each catchment area would elicit a better response.

Has VAMC Birmingham considered building an above ground, multi-story parking garage to alleviate the current parking issue? If so, is it more or less costly than leasing additional parking spaces?

If Greenville is having difficulty in hiring specialists, perhaps the VISN HR staff need to look at what they are offering these physicians versus what the civilian economy is offering them? Is it worth while to consider (a) increasing the salary levels, (b) hiring local specialists on a part time basis, or (c) contracting the specialist work load out?

VISN 8:

The VISN Summary, across the entire continuum, seems to concentrate more on the issues and visitations of assorted political leaders and does not address, nor even comment on, those Stakeholder issues from the veteran community. We would recommend that VISN 8 be tasked with rewriting their summary to discuss issues and solutions of importance to the primary Stakeholders – veterans and employees.

VISN 9:

Each of the four market areas within the VISN contains an identical narrative summary. It is extremely doubtful that the Stakeholders in each market area are totally satisfied and/or have identical issues with one another. We would recommend that VISN 9 be tasked with rewriting their summary to discuss issues and solutions of importance to the primary Stakeholders – veterans and employees – including the variations between market areas.

VISN 10:

The Central and West market summaries appear to show that ALL pertinent Stakeholders have been kept abreast of the CARES program and issues from the beginning and have had all important issues resolved. The Eastern market, however, appears to be courting the Congress and not keeping the Stakeholders involved. Perhaps a new approach should be mandated in this market.

VISN 11:

Each of the three market areas within the VISN contains an identical narrative summary. It is extremely doubtful that the Stakeholders in each market area are totally satisfied and/or have identical issues with one another. We would recommend that VISN 11 be tasked with rewriting their summary to discuss issues and solutions of importance to the primary Stakeholders – veterans and employees – including the variations between market areas.

VISN 15:

All primary concerns in VISN 15 appear to have been satisfactorily addressed.

VISN 16:

All primary concerns in VISN 16 appear to have been satisfactorily addressed.

VISN 17:

All primary concerns in VISN 17 appear to have been satisfactorily addressed.

VISN 18:

All primary concerns in VISN 18 appear to have been satisfactorily addressed.

VISN 19:

The VISN appears to have adequately addressed all major concerns and issues of their Stakeholders. However, there does appear to be a need for a primary care facility in many of the rural areas, containing relatively small veteran populations, of the VISN. Perhaps a thought to consider would be a Mobile CBOC. Perhaps a pair of modified Recreational Vehicles that travel throughout remote areas on a scheduled basis.

VISN 20:

All primary concerns in VISN 20 appear to have been satisfactorily addressed.

VISN 21:

All primary concerns in VISN 21 appear to have been satisfactorily addressed.

VISN 22:

The Paralyzed Veterans of America are opposed to converting 30 Acute SCI beds, at Long Beach, to Long-Term Care beds. The VISN has elected not to address the comments of FVA/CPVA as they conflict with the PI. The need for SCI beds is apparent to PVA. The VISN may or may not agree with them, however, a Planning Initiative is exactly the place for the comments to be discussed and recommended resolution of the issue be documented. Any PI should require the facility provide the best care, commensurate with need, of the veteran community that may reasonably be provided. It appears that the VISN doesn't consider the health care needs of veterans with SCI to be of importance.

VISN 23:

In the North Dakota market Stakeholders are rightfully concerned on how long the waiting time would be for an appointment at the proposed new CBOCs. The VISN's narrative states that "This was an issue that could not be answered at this time." Although we are quite sure that the issue could not be accurately answered, perhaps the issue could have been addressed differently. Unfortunately, many of our veterans do not have the knowledge and understanding of how these types of projects are planned and implemented. However, if you share your problems with the veteran community, allowing them to evaluate what you need to do, you'll find not only increased support, but, volunteers to help you meet your objectives.

Department of Defense Issues

AMVETS would like to congratulate those VISN Directors and the Medical Center Directors/Administrators who are successfully negotiating sharing agreements with Department of Defense Military Treatment Facility (MTF) commanders. We would also like to offer a few suggestions or thoughts on some of the sharing agreement areas of concern.

Veterans Integrated Service Network (VISN) 3:

- New York Harbor Health Care System;
 - The VISN discusses that they have not had a high level of success, when dealing with the Command at the United States Military Academy, West Point, NY, in finding an effective means of sharing some medical functions. The Director states that this is because the VAMC Montrose and the MTF West Point treat an entirely different class of patient. Montrose deals with long-term psychiatry, domiciliary and homeless issues, whereas West Point is training the young future leaders of the DOD. This is not an issue specific to these two facilities. The Veterans Health Administration routinely deals with a patient base of elderly, disabled, and indigent veterans. The DOD routinely deals with young men and women in excellent physical condition. These aspects do not seem to be an impediment in other areas. Perhaps the real reason that West Point does not want to go through the hard work of negotiating a sharing agreement is that the Director has already announced plans to basically close the Montrose facility. Please see "Small facility Issues" in your basic document.

VISN 4:

- VAMC Wilmington, DE
 - We'd really like a little more amplification here. What was reviewed? Why was it not feasible?
- VAMC Philadelphia
 - We'd really like a little more amplification here. What was reviewed? Why was it not feasible?

VISN 6:

- VAMC Durham, NC
 - "The Navy has decided not to participate in the project at this time." Why did the Navy choose not to participate? Is there a better time frame for the Navy to participate?

VISN 7:

- CBOC Summerville
 - It appears that more discussion between the VISN and the Navy is in order. In truth, there may not be an opportunity, however, based on the summary, we don't believe that the VISN or the Navy really understood the seriousness of the discussions.
- CBOC Beaufort
 - The implication made in the summary that spending \$3,000,000 on 1,500-2,000 veterans is not cost effective should be offensive to the veteran community and the VHA administration. The government risks multi-billions of dollars worth of resources to equip, defend, and support the 1,953 Marines and Sailors in a Marine Expeditionary Force Combat Team. Expending an additional \$3,000,000

o provide a location to give these veterans health care should be also be of highest priority.

VISN 9:

- VAMC Louisville
 - o Perhaps, as per your narrative summary, a sharing agreement isn't as important in this area as replacing the VAMC with a new facility in a better location.

VISN 17:

- VAMC Dallas
 - o "The only interest so far the clinic (Navy) leadership has expressed in is the possibility of VA helping them with the large retire(d) pharmacy workload the clinic experiences." This statement makes it sound like the Navy staff doesn't understand its own pharmacy programs. Prescriptions filled at an MTF are filled free for eligible beneficiaries. Beneficiaries using TRICARE pay a \$3.00 co-pay, whereas those using VA pay a \$7.00 co-pay. Perhaps the VISN should show/explain in detail how sharing some programs would be cost effective to the Department of Defense and either retain the same, or lower cost, to the military personnel.

VISN 18:

- VAMC Phoenix
 - o Although Phoenix has done what it can to set up sharing agreements with Luke AFB, "Progress is currently on hold pending the return of key individuals from the war in Iraq." The fact that certain individuals have deployed to Iraq is no reason for the negotiations to stop. The negotiations should be ongoing with those USAF personnel who have temporarily filled the vacancies left by deployment.

It is apparent from the narrative summaries that many VISN Directors and MTF Commanders are actively collaborating to provide the best possible health care at the lowest possible cost for their beneficiaries. It is equally apparent that some VISN Directors and some MTF Commanders are not.

There are a number of issues that need to be addressed across the board. The primary issue becomes one of military security and access to MTFs by VHA beneficiaries. A large number, but by no means the largest, of VHA beneficiaries are military retirees. These men and women do not have a problem accessing MTFs. Many installation Commanding Officers, however, refuse to grant access to those veterans who are not military retirees. As VHA beneficiaries carry an identification card which has their name, social security number, and photograph which isn't much different than the information found on the front of a military identification card, the military installation security offices should be able to issue visitors passes to these men and women specifically delineating they are only authorized to use the most direct route from the installation entrance to the MTF. Another alternative would be to issue these individuals access decals for their vehicles similar to those currently issued by DOD. Current window decals are Blue for Commissioned Officers, Red for Enlisted Personnel, Green for Civil Servants, and Black for Contractors/Vendors. Perhaps a white decal or striped decal could be issued for VHA personnel and beneficiaries?

One point that seemed to crop up in many of the narrative summaries is that due to the war in Iraq many negotiations had to be placed on hold. The war should be the catalyst to expedite the negotiations. The DOD and MTFs tell us that many of their medical personnel have been deployed to the Mid-East and therefore the MTF is understaffed and cannot (a) make decisions or (b) accept additional workload. At the same time, many VHA medical and administrative personnel serve in the Military Reserve and the National Guard; they too have been deployed either to the combat theater or to MTFs to replace those active duty personnel who were deployed. Therefore, the VHA is also operating short handed. Combining operations between VAMC/CBOC/MTF would seem quite necessary at this time, when neither organization has ample staff on hand to treat their patient load.

Small Facility Issues

AMVETS has some issues with a few of the recommendations made by various VISN Directors. Comments below are only applicable to those specific recommendations with which AMVETS disagrees.

Veterans Integrated Service Network (VISN) 3:

- Hudson Valley Health Care System;
 - The VISN Director has recommended that Nursing Home and Inpatient Psychiatric Services be relocated from the Franklin Delano Roosevelt (Montrose) Campus of HVHCS to the Castle Point Campus of HVHCS.
 - The training of key staff personnel at the two facilities does not appear to be similar. Montrose is a Geropsychiatric and Substance Abuse facility, whereas Castle Point is a General Medicine facility. Would staff personnel at Castle Point be able to provide the necessary treatment based on their levels of expertise? Would psychiatric staff personnel be transferred from Montrose to Castle Point? If so, who would be available to operate the outpatient psychiatric and domiciliary services retained at Montrose?
 - The two facilities are approximately 26 miles apart. During the winter months this extended drive would prove hazardous to both elderly patients and/or their visitors. Winter driving conditions and the reduced visual acuity of the elderly would provide the potential for traffic accidents resulting in either death or serious injury.
 - The VISN Director has recommended that Spinal Cord Injury cases be transferred from Castle Point to Bronx VA Medical Center.
 - AMVETS feels that the only issue here is the extended travel distance of approximately 80 miles, some of which will be through high density traffic areas. Bronx VAMC maintains an SCI Center and, medically speaking, this recommendation could prove beneficial to the patients.
 - It is our opinion that the VISN Director is mistaken in that extended travel times/distances will "maintain access to quality care while allowing efficient utilization of resources." Although efficient utilization of resources and cost containment is important to any operation, the primary objective of the Veterans Health Administration is to provide health care for our veterans. In some of these recommendations health care for veterans will be hindered.

VISN 7:

- The VISN Director has apparently made a recommendation regarding Dublin VAMC, however, the Small Facility Issue Summary for this facility is incomplete. Based on the missing data/information, AMVETS has no comment at this time.

VISN 11:

- The Northern Indiana Health Care System – Fort Wayne Division:
 - This is a 423 bed (180 of which are Nursing Care beds) facility located in the second largest city in Indiana. The facility provides primary and secondary surgical care, chronic and acute psychiatric care, nursing home care, and extended care. The VISN Director states that the division provides a high

quality level of care and is relatively cost efficient. The facility appears to have over 17,000 enrolled patients and provides the support for two Community Based Outpatient Clinics with two more in the planning stages. However, the VISN Director wants to convert the facility to Primary, Specialty, and Mental Health Outpatient Care. The Director wants to close the Acute Medical Beds at Fort Wayne; have patients requiring inpatient emergency care receive that care in the community and transfer any remaining acute care patients to the Richard L. Roudebush VAMC in Indianapolis. The Roudebush facility is a tertiary care facility with fewer beds than Fort Wayne. Additionally, the two facilities are over 128 miles apart requiring patients and/or visitors to travel for more than two hours. During inclement weather and after dark, this type of trip is hazardous to our elderly veteran population. What would happen to the NHCU patients if they required acute care beds? Would those patients who are "grandfathered" and don't have to pay the \$97 per day co-payment be transferred to a local facility or to the Roudebush facility, than when they return, be readmitted to the NHCU with a co-pay?

- Aldea E. Lutz VAMC, Saginaw, MI:
 - The Summary Page on this facility tells us that it oversees three CBOCs with a fourth planned; has over 15,000 enrolled patients in a county of 210,000 residents. The VHA Web Site, however, tells us the facility serves the 47 central and northern counties of the Lower Peninsula and that these counties have a veteran population of over 211,000 veterans. The facility has recently undergone extensive renovations to its inpatient facilities. In the meantime, the VISN Director recommends retaining the facility as an Outpatient Care Facility and transferring all of the Acute Care Beds to Ann Arbor (86 miles/1 ½ hour drive) and Detroit (102 miles/1 ¾ hour drive). Additionally, the VISN Director feels that those patients requiring inpatient services in the northern counties of Lower Michigan receive care in the community at VA expense and those in the Saginaw area receive their care in the community. There is no mention of "VA expense" for the Saginaw area veterans. Additionally, the VISN Director recommends transferring inpatient psychiatric patients to Battle Creek VAMC, 142 miles and 2 1/2 hours away.

VISN 20:

- Jonathan M. Wainwright Memorial VAMC, Walla Walla, WA:
 - This is a 66 bed facility with a 30 bed NHCU and a 22 bed Psychiatric/Substance Abuse unit. The next nearest VAMC is in Spokane, WA, 157 miles and a four hour drive away. The VISN Director has recommended closing the Acute Care beds and implementing contracting with local medical facilities. The VISN Director states that the facility is located in a small rural community, which it is. Walla Walla County only has a population of 56,149 residents. However, the three adjoining Washington Counties (Benton, Columbia and Franklin) and the four adjacent Oregon Counties (Morrow, Umatilla, Union, and Wallowa) bring that area population to 377,885 with an estimated 37,217 veterans (US Census Bureau figures). If contracting takes place, what will happen to VAs Continuity of Care? Will the civilian medical practitioners be current in veteran specific programs such as "Undiagnosed Illnesses"?

VISN 23:

- Black Hills Health Care System – Hot Springs Campus:
 - The only issue at Hot Springs is the proposed contracting of higher levels of care with Rapid City Regional or Regional West in Scottsbluff, NE. Although we applaud the Director's plan we do have questions concerning the administrative aspects of this portion of the plan. Will VA receive copies of all medical records maintained by the two civilian facilities? Will these records be entered into the Electronic Health Record of the veteran? How will Continuity of Care and Patient Management by the Primary Care Provider be handled?

- Central Iowa Health Care System – Knoxville Division:
 - There is really only one concern with the recommended plan. It doesn't appear to address the cost issues of combining the facilities at Des Moines versus combining the facilities at Knoxville. Knoxville currently maintains 226 Nursing Home Care Unit beds while Des Moines has none; Knoxville has 40 Domiciliary beds to Des Moines 38; Knoxville has 34 Psychiatric beds to none for Des Moines; Knoxville has 20 Intermediate Care beds to Des Moines zero; and Des Moines has 47 Acute Care beds while Knoxville has none. Logic would seem to dictate that it would be less costly and more time efficient to build additional facilities at Knoxville and than combine the two Medical Centers at that site.

- VAMC St. Cloud, MN:
 - This facility maintains 391 Operating beds, 200 Long Term Care beds, 123 Domiciliary beds, 25 Psychiatric Residential Rehabilitation beds, 15 Psychiatric beds, and 8 Medical beds. The VISN's plans include converting the 8 Medical beds to Sub-acute Care beds and transferring 50% of the workload to VAMC Minneapolis and the remaining 50% to the local community health care system. The summary didn't enumerate which services would be transferred out; inpatient, outpatient, or both. It would appear to us to be an error to change the status quo at this facility. The Minneapolis facility is approximately 66 miles, or 1 ¼ hours drive, during good weather. During the severe inclement weather Minnesota often experiences this drive would be hazardous to our many elderly veterans and their families. St. Cloud currently maintains 321% of the bed space that Minneapolis maintains. Moving approximately 381 beds to Minneapolis would be an expense that VA doesn't need. Additionally, St. Cloud Hospital only has 489 beds available with an average daily utilization of 58.9%. This would leave St. Cloud with only 288 available beds to cover the remaining 381 beds at VAMC St. Cloud. The civilian facility is 75 years old and a Catholic facility. The religious affiliation of the hospital could be offensive to some VA patients. The VAMC is a newer facility than the civilian facility. It appears that there is a moratorium on building new hospitals or adding bed space within Minnesota. Although a competing firm has requested a waiver from the moratorium to build a second facility in St. Cloud, the existing facility is fighting the request. If such a moratorium does exist, how is the local community going to be able to accept an increased patient load?