

LANE EVANS
Comments on National Draft Plan for Capital Asset Restructuring for
Enhanced Services (CARES)
VISN 11

General: VA has not addressed the needs of veterans with serious mental illness or those in need of long-term care in this phase of CARES. VA immediately dismissed the outcome of its own long-term care model that projected a need for 17,000 nursing home beds by 2022. The Administration also lacks a plan to prioritize and call for the significant investments necessary to make the promised enhancements in its Plan.

Central Illinois Market

Primary Care: The Central Illinois market in VISN 11 has and will continue to have too many counties that do not meet VA's access standards under the National plan. Some counties, including Champaign, McLean, and Coles already have enough veterans enrolled who are not within VA's access standard to constitute a panel size (about 1200 veterans) that would justify the creation of a community based outpatient clinic. Undoubtedly, more veterans would seek primary care if such services were more accessible. Other counties with fewer veterans but in which more than 70% of enrolled veterans have primary care access problems include: Cass, Christian, Clark, Crawford, Cumberland, DeWitt, Douglas, Edgar, Ford, Fulton, Iroquois, Jasper, Livingston, Logan, Marshall, Mason, Menard, Moultrie, Shelby, Woodford, and Benton, IN. VA should look for partnering opportunities with community health clinics to help address needs in some rural or underserved counties without access.

The network plan identified three sites that they believed could address the market's significant problem with access to primary care including Bloomington, Champaign-Urbana, and Charleston, IL. It also intended to enhance the outpatient clinics at the Illiana Healthcare System and the Peoria CBOC. VA is touting that, nationally, CARES will ensure that 74% of its veterans meet its access standard for outpatient care. However, VA Headquarters omitted the clinics the Network plan identified to allow it to meet the standard for 70% of its enrolled veterans from the Draft National Plan. Omitting these clinics means that the network continues to fail to meet its national access standard for almost half (46%) of the market's enrolled

veterans, relegating veterans in this market to a much lower standard of access than most of the nation's veterans will enjoy. I hope that the Commission will share my view that this is unacceptable.

Acute Hospital: The National CARES Plan aims to improve access to hospital care from its current 72% to 84% of VA's enrollees. In the Central Illinois market, 36% of those enrolled meet VA's access standard for acute inpatient hospital care. Both the network and national plans aim to increase the percentage of enrollees meeting the access threshold to 72% by redirecting an average daily census of 17-20 to local hospitals on contract at two sites. While a significant improvement for these veterans, this initiative will bring the standard of care for Central Illinois veterans to the average level available to veterans elsewhere in the nation *right now*.

In order to improve access to acute hospitalization, the Commission might consider additional initiatives. One alternative is identifying additional sites that will have access to local hospitalization by contract—Decatur; Lafayette, IN; Tazewell Co., and Normal/Bloomington. A second innovative alternative is partnering with an affiliate such as University of Illinois-Peoria School of Medicine to provide “critical access” hospital care in VA-operated beds somewhere on the campus. Hospital beds in Peoria would open access to veterans in that area and meet the hour access-time threshold for two-additional population bases--Springfield and the Normal/Bloomington area. In this arrangement, VA might have the critical mass necessary to operate about 20 VA beds and could negotiate discounted rates for ancillary services with the affiliate.

Indiana Market

Acute Hospital: The Northern Indiana Health Care System may present unique considerations regarding long term care, mental health care, and acute medical/surgical care. This VA health care system contains two main campuses – separated by nearly 60 miles – and a number of CBOCs. The attempt to integrate services between main campuses has created management difficulties based largely on geographical considerations. In its most recent iteration, VA would place Medical/Surgical beds in Ft. Wayne, IN Campus and place long-term care and psychiatric care at the Marion, IN Campus. This option limits options for veterans presenting at Marion with acute care needs. The Long-Term Care facility may generate a disproportionate number of patients with acute care needs. Integrating acute

care services at one facility requires VA to transfer patients to either the Ft Wayne or Indianapolis VA Medical Centers, or transfer them to the Marion Community Hospital. This arrangement does not appear to be cost efficient or sensitive of patient needs. The House Committee on Veterans Affairs has questioned the plan to discontinue the acute care services at Marion for this basic reason. I encourage CARES Commissioners to review the agreement reached between Secretary Principi and myself (dated: June 30, 2003) detailing the terms of the temporary suspension of acute care services at Marion to permit an accurate assessment of the financial and quality of care impact of the loss of those services.

VISN 11

Specialized Care: Public Law 104-262 requires VA to maintain the capacity of certain specialized services such as those for mental illness, homelessness, blindness, spinal cord injury and prosthetics. Since Congress has dated information about the maintenance of capacity in VA's specialized programs, the following comments are based on the Capacity Report for 2001.

VISN 11 has not had a good record of maintaining the number of individuals treated in its specialized programs for seriously mentally ill veterans, including those with psychoses. VISN 11 must keep up the progress it is making with implementation of Mental Health Intensive Case Management programs and outreach to the seriously mentally ill across the network. Veterans with dual diagnosis should also be targeted with a broad array of services to meet their needs including outpatient and inpatient substance abuse treatment programs, residential treatment programs, and inpatient treatment options.

I am supportive of adding blind rehabilitation outpatient specialists at the 7 sites of care delivery in the network. VISN 11 should maintain an active partnership with spinal cord injury centers in adjacent networks.

Long-Term Care:

Public Law 106-117 requires VA to maintain VA nursing home beds at the level that existed in FY 1998. The Committee on Veterans Affairs is actively overseeing VA's compliance with this law despite the fact that VA overtly left response to veterans' long-term care needs out of this Phase of

CARES. I am pleased to support the proposed enhanced use lease for VA-operated nursing home beds at Illiana VA Medical Center.