



Veterans of Foreign Wars of the United States

VETERANS SERVICE

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**** SALUTATION****

The Veterans of Foreign Wars is concerned that Long Term Care, Mental Health, Enhanced Services, Homeless Veterans and Domiciliary are not addressed in the CARES model. The VA has failed to meet its statutory obligation to maintain capacity to provide extended care services. The nursing home average daily census (ADC) provided by VA in fiscal year 1998 was 13,426 compare to 11,974 in fiscal year 2002. This shortfall is of particular concern because according to the General Accounting Office (GAO) the "veterans population most in need of nursing home care – veterans 85 years old and older - is expected to increase from almost 640,000 to over 1 million by 2012 and remain at that level through 2023". Clearly, nursing home care demand is about to be at an all time high, but is consistently lacking in the cares model.

It is estimated that more than 275,000 veterans are homeless on any given night. More than half a million veterans experience homelessness over the course of a year. Health care both physical and mental is vital for many homeless veterans to gain and hold employment. The VA mental health and substance abuse programs are essential to making homeless veterans job ready. Our concern is that Homeless vets and domiciliary are not addressed in the CARES model.

Our Nations Veterans have continually sacrificed their mental wellness and physical well being in the defense of this great Nation. World War II veterans, Vietnam veterans, Korean War

veterans, Gulf War veterans, and now our veterans from the Iraqi Freedom conflict will need mental health treatment/counseling. Their needs may involve a series of treatment in an inpatient psychiatric unit or several out patient visits, but the number of veterans who are in need of these services are not decreasing but increasing and once again these programs are not accurately projected in the CARES model.

Overall, Enhanced services were addressed but not where the funding for additional staff will come from or how much, but long term care, homeless vets, domiciliary or mental health still remained issues that were not addressed.

The intent of CARES would be to improve efficiency, effectiveness and to enhance the level of functioning of which we have not seen thus we ask again, where are the enhanced services?

Access to primary care, acute hospital care, tertiary care:

Acute hospital access: only 53% of Enrollees are within the Access Standard. Plans are to expand fee basis contracts with community hospitals.

Proximity 60-mile, 120-mile)

Palo Alto Medical Center and San Francisco Medical Center are 45 miles apart. The Medical Centers have proposed consolidations of administrative and clinical programs. Neither facility has the bed capacity, infrastructure nor clinical staff to accommodate the full workload of the other.

Infrastructure: This VISN has major seismic safety issues. Of the top 77 Exceptionally high risk buildings in VHA 3, 3 VISN 21 structures rank 1st, 2nd, and 3rd with regard to seismic deficiencies.
1st San Francisco's Building 203 (Main Hospital Bed Tower)
2nd Palo Alto Divisions 's Building 2 (Acute Inpatient Psychiatry)

3rd Palo Alto Divisions Building 4 (Consolidated research activities)

Mission Change Analysis:

VISN 21 was tasked to "evaluate a strategy to convert from a 24-hour operation to an 8 hour operation" at the Livermore Division. In order to effectively realign the Livermore Division, existing and projected out-patient and in-patient workload would be redistributed. Many San Francisco bay area residents migrate out of the region and locate in the Central Valley. The majority of veterans who use Livermore reside in the Central Valley and East Bay. Veterans increasingly use specialty care services at the Livermore Division enhancing primary care and mental health services at the Stockton, Modesto and Sonora CBOC's would be needed. In 2002, nearly 10,500 veterans obtained medical care at Livermore.

LIVERMORE'S OUTPATIENT SERVICES:

Establish a new 35,000 ambulatory care clinic in the Central Valley, which would enhance Primary Care, selected specialty care and ancillary services. Relocate the ambulatory care functions from the Livermore Division to a new site in the east bay involving primary care, specialty care, out-patient procedures, ancillary and diagnostic services.

LIVERMORE'S INPATIENT SERVICES:

Relocate Livermore's Divisions 30 sub-acute/intermediate medicine beds to Palo Alto Division. Use vacant ward space in the new building 100 bed tower to consolidate all sub-acute/intermediate medicine beds within the Health Care System. Extended care would be addressed by relocating 80 NHCU beds from Livermore to Menlo Park (dementia, respite, hospice and extended care). Construct a new 200-bed extended care nursing home in Menlo Park incorporating the 80 beds from Livermore and 120 beds for the seismically deficient Menlo Park. Contract remaining 40 NHCU beds to facilities in the community (Stockton,

Modesto and Sonora) to reduce the hardship on veterans who reside in outlying Central Valley communities.

The proposed plan would eliminate unneeded buildings from the VA inventory, streamline operations and reallocate resources to direct patient care, reduce redundant operations and consolidate duplicative functions. There may be an opportunity for an Enhanced Use Lease at the Livermore Division. That would have to be investigated.

The V.F.W. is also greatly concerned with keeping the families involved in the Veteran's care. There is a movement of veterans out the urban area into the valley due to the cost of living and they felt the migration had not been reflected in the CARES model.

Congressional Representation indicated there are access issues. There are clinics but not in the Northern Area and there needs to be inpatient services for elderly, fragile veterans.

Seismic issues are of great concern. Many projects have been approved but not funded by congress. We do not want these projects lost in the CARES process. CARES could work – but as in the past- politics and monies rear their ugly head.

The House of Representatives has passed a VA spending bill that severely under funds veterans' health care by some \$2 billion below the level called for in the congressional budget resolution. "This bill falls woefully short of what's needed for America's sick and disabled veterans and represents a flagrant disregard for promises made by this Congress to fund veterans health care at 29 billion amid all the high sounding rhetoric and promises to support special interests, politicians have all but ignored America's sick and disabled veterans. We must not let the Administration and Congress Turn their backs on the veterans health care system. For years, the Department of Veterans Affairs has been unable to

provide health care to hundreds of thousands veterans because of their inadequate budgets. The problem starts at the White House Office Of Management and Budget where the bean counters consistently pare back the VA's budget request to accommodate the other priorities of the Administration.

Legislation pending in the United States Senate (S. 50) and the House of Representatives (H.R. 2318) would guarantee adequate funding for the VA so that veterans would have timely access to medical care. These bills also have bipartisan support in both the House and Senate, but the Congressional Leadership and the White House are adamantly opposed to this practical solution to the veterans health care crisis.

GEORGE WASHINGTON STATED:

“The willingness with which our young people are likely to serve in any war, no matter how justified, shall be directly proportional to how they perceive the veterans of earlier wars were treated and appreciated by their nation.”

Unfortunately, without urgent changes in health-care funding, our new veterans will soon discover their battles are not over. They will be forced to fight for the life of a health care system that was designed specifically for their unique needs. Just as veterans of the 20th Century did, they will be forced into a long standing battle to fulfill America's promise to make that system accessible to all veterans. The V.F.W. of the U.S. believes no veteran should be forced to fight for the care he or she is entitled to receive. We believe it is time to guarantee health care funding for all veterans. We believe health care rationing must end.

WE BELIEVE IT IS TIME THE PROMISE IS KEPT!

Capital Assets Realignment For Enhanced Services

Livermore, CA
October 1, 2003

Good Morning. My name is Karl Schroth and I am the chairman of the Alameda County Veterans Affairs Commission, a committee appointed by the Alameda County Board of Supervisors. We are a coalition of major veterans organizations that include the VFW, the American Legion, Disabled American Veterans, Vietnam Veterans of America, Pearl Harbor Survivors, Former American Prisoners of War, Fleet Reserve Association, Gulf War, Iraq and Desert Storm Veterans and Women Veterans.

Advocates for veterans, like the Alameda County Veterans Affairs Commission, are not alone in their efforts to address health care issues before the Veterans Administration. Our Commission speaks on behalf for well over 105,000 veterans who reside in Alameda County. Based on demographics prepared by the Northern California Healthcare regional office, 2/3 of the county's veteran population resides in the east and south end of the Bay Area.

When compared to other surrounding Bay Area Counties with large veteran populations, it is easy to see that Alameda is historically short-changed with respect to allocation of VA medical facilities. San Francisco, for example, with a veteran population of 42,792 enjoyed VA medical expenditures of \$244 million dollars in FY 2002. Contra Costa, with a veteran population of 75,542 had VA medical outlays in excess of \$203 million dollars.

By contrast, Alameda County, with a veteran population of over 100,000 had VA medical expenditures of less than \$44 million dollars. In essence, Contra Costa and San Francisco counties with roughly the same amount of veteran population benefited from 10 times the medical expenditure outlay per veteran as Alameda County Veterans.

Now, under CARES, the administration wants to reduce the available facilities or expenditures in Alameda County even further. Alameda County veterans already find themselves having to travel considerable distances outside the County to receive VA medical care for many of their medical needs. Without services at Livermore or the Livermore area, half of Alameda County and a good portion of San Joaquin County will be forced to either travel long distances to the nearest VA facility for their needed treatment, or forego VA care altogether.

It is unthinkable that the Bay Area County that has by far the largest veterans population be reduced to having only one clinic, which is currently overwhelmed with patients from the Oakland area alone.

Also unthinkable is the idea that the VA will somehow be able to arrange a transportation network to ferry veterans to available facilities outside of the county. A large percentage of elderly veteran patients are unable to drive or obtain public transportation. Add to this mix the perpetual gridlock that exists on most Bay Area freeways and bridges and the overstrained volunteer van services, and one can see a future where the number of late and missed appointments at VA facilities rises dramatically. The resulting frustration both for providers and veterans as well as the increased danger of serious medical conditions not being treated in a timely manner will only serve to damage the relationship between the VA and its constituency,

and end up increasing medical expenses and settlements from medical care that is unavailable because of time and distance.

Our WW II veterans are passing on at a dramatic rate and many are suffering long-term care needs. Korean War vets are aging and continue to suffer the mental and physical wounds of their war, Vietnam veterans are still trying to reconcile the effects of exotic diseases that the VA only recently has begun to recognize and accept. Those veterans are marking time and desperately trying to keep pace with the changes in the VA healthcare system.

Add to this same frustration of the expanding veteran population coming from a new generation of wars, Desert Storm, Somalia, Iraq, Afghanistan, etc. who must face the same dilemmas our aging veterans faced when they came back from their wars. The VA is also facing a whole new culture of veteran, women veterans, with conditions unlike those of their male counterparts. One wonders if the VA is prepared to deal with these new issues. It appears that the VA is trying to camouflage those needs by closing down hospitals and playing a turf war with VA regions throughout the country. The VA needs to establish concrete, plausible alternatives before it releases statements about the closing of certain facilities.

Given the need to implement the CARES program, we would like to make a case for our district. Looking at the physical needs such as hospitals and clinics is a whole new dimension for veteran's advocates to deal with. We need to look at the impact on the demographic mix in Alameda County. We need to consider alternatives to the potential out patient clinic sites that can serve the existing veteran population in its own community instead of playing regional turf wars and empire building.

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09/17/03

**Everett Alvarez, Jr.
Chairman CARES Commission
Department of Veterans Affairs
Washington DC 20420**

Dear Mr. Alvarez, Jr.,

Thank you for your personal invitation to appear before the Commission at the public hearings on October 2, 2003 at McClellan, Ca.

Due to the distance of travel, (5hours one way) NOVA must decline but shall give the following response to Mr. Richard E. Larson at his E-Mail address.

Shasta-Butte a part of the VA Sierra Pacific Network VISN 21 due to the distance of travel,(3 to 7 hours one way) to the nearest VA Medical Center is in dire need of Urgent Care beds contracted locally. The Sacramento VA Medical Center with its new tower cannot support the demand from our established population growth. We need local contracts for specialty care for our Veterans with Female problems, Cancer Treatment and Cardiac Care. We also need increased space and staff at the Redding VA OPC because current staff cannot maintain the present t work load, let alone the anticipated increases over the next 20 years.

In closing, we are asking the Commission to investigate the fact that even though the North Valley Division of VA Sierra Pacific Network VISN 21 show numbers of a decreasing Veteran population, Shasta-Butte shows numbers of increases as high as 48% in some counties. The expansion to the Chico VA OPC will only address the problems of that geographical area with in a 1 hour distance of the Sacramento VA Medical Center; therefore leaving Redding VA OPC with out a committed program to address their projected growth. The Commission has the privilege to use their foresight to fix a problem before it becomes a catastrophe.

**D.J. Boardman
Chairman**