

**Region 10 Lead Agent Testimony to Capital Asset Realignment
for Enhanced Services (CARES) Commission
Colonel James Collier, MC
1 October 2003**

*Commander of
Med Group at
Vesper*

Mister Chairman and honored members of the CARES Commission, thank you for this opportunity to provide a response to the CARES draft national plan. It is an honor to speak to you today as you are preparing to shape a future of superior health care for our nation's great and deserving veterans.

Former Air Force Surgeon General, Lt. General Paul K. Carlton, Jr. gave voice to our philosophy when he said that it is a pleasure to serve our country and a privilege to provide compassionate health care for the great patriots who have served, are serving and will serve our great nation. He also said that it is our duty and responsibility to be reasonable with our health care dollars and to be relevant to our true beneficiary needs.

Therefore, I believe that collaborations between the DoD and VA serve this philosophy and are imperative. Fortunately, I am joined in our region by a VA leadership team who feels the same way.

In northern California, we have a long history of DoD/VA sharing and collaboration, most visible now in our sharing agreement and in our joint

campus of David Grant Medical Center and the VA Northern California Health Care System Fairfield Outpatient Clinic.

Today, our sharing is at the highest levels in the region's history. I believe that has been made possible by regularly scheduled meetings with key DoD and VA medical leadership in northern California. Examples include, first, our Joint Initiatives Working Group which reports to our Executive Management Team on DoD/VA collaborations and, second, the Office of the Lead Agent/ VISN 21 Liaison Group that looks for sharing opportunities throughout the region. *Board of Gov. met quarterly & Lisa Freeman in attendance.*

As Commander of the 60th Medical Group, I'm proud of the comprehensive master sharing agreement between David Grant Medical Center and VA Northern California Health Care System that includes arrangements for the sharing of inpatient services, outpatient specialty services, ancillary services, and the outpatient clinic building right on our campus.

As the Lead Agent for Region 10, I'm also very excited about new, in-progress and future initiatives in DoD/VA sharing in northern California.

At Naval Hospital Lemoore, there is an agreement for a VA contracted physician to provide separation physicals for active duty members. There is also an agreement whereby the VA performs Magnetic Resonance Imaging (MRIs) for Navy active duty members at Lemoore through TRICARE. The sharing of Urology/Lithotripsy services between the Navy Hospital and Fresno VA Hospital is in the final stages of approval at the Naval Bureau of Medicine (BUMED).

Through the Presidio of Monterey Army Health Clinic, a joint venture is being considered for the possible building of a VA facility to serve both VA and DoD special care needs. An economic analysis still needs to be performed, however, the high costs of this area makes it an ideal location for consideration for such an initiative.

The Army Reserve also participates in sharing through agreements in the Region under the FEDS_HEAL program to perform physical examinations.

In Sacramento, we are looking at a joint pharmacy venture at the VA McClellan Outpatient Clinic where we currently already have a satellite Air Force medical presence sharing space with the VA. We are also investigating opportunities for joint medical services research between local VA centers for research, David Grant Medical Center, and major universities in the area. Our hope is to tap into the world-class research environment in the bay area to enhance our Graduate Medical Training and our ability to answer population health questions never before investigated through the use of jointly-shared longitudinal data bases.

Now, to get to the reason you've asked me to be here today: we have found that collaborations and sharing work best when we can take advantage of any excess capacity within the total system. We have examined the proposed CARES plan to see if it either detracts from or adds to the total capacity of the system in our region. We do not feel the proposed changes here at Livermore will detract from capacity in such a way as to create problems for the DOD. We have about 2800 TRICARE beneficiaries in the Livermore area but do not feel that this proposal will adversely effect their access to health care. If the providers who will be employed at the new or expanded community based outpatient clinics mentioned in the proposal are

or continue to be TRICARE network providers, we feel that this will possibly create some increased capacity to care for our TRICARE eligible beneficiaries. In addition, as the ability to care for more outpatient needs is made manifest within the VA, we feel that our unique position as a well manned graduate medical training center gives us excess capacity in several medical and surgical specialties that may allow us to help with any increase in specialty care needs resulting from the increased access the VA proposes through this plan. So, to summarize my opinion: in Region 10, we greatly support the CARES initiatives for the North Coast and the South Coast and, as a medical treatment facility (MTF) commander and Lead Agent, I can greatly appreciate the work that has gone into this plan and the positive impact it will have on these areas and beneficiaries for years to come.

Mister Chairman and CARES Commission panel members, thank you for the opportunity to present my views to you today. I share with you the pleasure and privilege we have to serve our nation's patriots.

(timed at 4 minutes, 15 seconds)

VISN 21 - VA CARES Commission Testimony
Tripler Army Medical Center/Pacific Regional Medical Command
1 October 2003

Good morning. I am COL Frederick Gargiulo, Chief of Staff for Tripler Army Medical Center and the Pacific Regional Medical Command. It is my pleasure to have the opportunity to address The Veterans Affairs CARES (Capital Asset Realignment for Enhanced Services) Commission and provide information concerning our Joint Venture program in Hawaii on behalf of our commander, MG Joseph Webb.

Tripler Army Medical Center has been providing inpatient beds for veterans since 1933. Today, Tripler and the VA Pacific Islands Health Care System cooperate in a Joint Venture comprising over 70% of the reimbursement for VA/DoD sharing nationwide. In addition to the inpatient medical, surgical and psychiatric services provided, specialty outpatient services and ancillary support have also been developed over the past decade and exist as mutually beneficial agreements today.

In May 2000, the VA completed their relocation from downtown Honolulu to facilities on the Tripler campus. The VA now occupies and manages the Center for Aging, a short term rehabilitative/psychiatric facility completed in 1995, a newly renovated wing of Tripler accommodating office space for the VA headquarters and administrative functions completed in 1999, and the VA Ambulatory Care Clinic dedicated in May 2000 - all located on the Tripler campus.

Tripler is responsible for providing health care to over 270,000 eligible beneficiaries, ranging from active duty service members from all branches of service to family members, retirees and their family members. Additionally, veterans and Pacific Island nation residents are also provided

health care under separate special programs. On an average single day at Tripler, seven veterans will be admitted to inpatient wards, 60 outpatient specialty visits will occur, as will 17 x-ray procedures, 110 laboratory tests, and the filling of 41 prescriptions. This workload is in addition to the medical workload being accomplished within the VA's co-located facilities. The current collaborative efforts have resulted in an interdependence that has moved both organizations closer to providing seamless health care.

In fiscal year 2002, over \$17 million in health care and other services was shared. While reimbursement is essential to a successful DOD/VA partnership, it is not either partner's primary motivation. Another dimension of caring for the veteran is that the illnesses and surgeries associated with aging are very relevant to keep active duty medical personnel trained and ready for the battlefield mission. We need to stay competent by caring for acutely ill patients. Graduate medical education also benefits from caring for the veteran population. Tripler has a very robust Graduate Medical Education Program. We train several hundred physicians in 14 different specialties. Also, we appreciate caring for VA beneficiaries because for the military, caring for veterans represents a continuation of the services provided when veterans were on active duty. We consider our active duty as "veterans in training" and consider our partnership a win-win relationship for all involved.

We are ahead of most localities in that we are already one of the most functionally integrated joint ventures. In an effort to maximize use of both of our collective resources, the Joint Venture was developed to provide care through a shared arrangement, saving substantial federal dollars that would have otherwise been spent for the construction of a separate VA medical

center. So, instead of two freestanding inpatient medical centers, we have only one emergency room; one inpatient medical and surgical service, a co-located psychiatric service; and essentially one major specialty outpatient service.

In yet another example of our collaboration, a Memorandum of Understanding was executed between the Tripler Army Medical Center and the Veterans Affairs Medical and Regional Office Center, Honolulu to establish a unique partnership, the Pacific Telehealth and Technology Hui. The Hui's purpose is to leverage their mutual strengths and resources to improve the quality, accessibility, patient satisfaction, and cost-effectiveness of healthcare services provided to beneficiaries through the use of emerging and existing telehealth technologies.

As an example, in 2002, the Hui deployed Phase I of a bi-directional pharmaceutical interface developed in collaboration with the Veterans Health Affairs Office of Information System Design and Development. The interface enables physicians at Tripler to enter prescriptions into the workload tracking system at Tripler and transmit the information via the VA workload tracking system to the VA pharmacy. Phase II of this project will complete the bi-directional circle and permit VA clinicians to generate pharmaceutical orders at their clinic and have them filled at the Tripler Pharmacy.

There is also concern that we, as a joint venture, need to develop well-defined business processes that will better enable efficient coordination. This opportunity to improve can address our current systems that cause delays in billing and payment. Lack of advanced automation systems for financial structures, specifically addressing the ability to complete itemized billing, also contribute to the imperfect business environment of current joint

venture sharing. Sharing and resource coordination, as well as improved strategic planning and forecasting, is needed. We must address and resolve the barriers described if we are to achieve our ultimate goal - high quality care for our respective beneficiaries in a shared, seamless healthcare system.

In August 2003, a Health Care Sharing and Resource Coordination Project proposal was jointly submitted to the VA/DoD Health Executive Council for consideration to make the Hawaii Joint Venture one of the three nationwide demonstration sites requested by Congress. Our project proposal would cover two major projects - a Budget and Financial Management System and components of a Medical Information and Information Technology System. The project would include structure and processes to jointly assess, execute and evaluate Health Care Forecasting, Demand Management and Resource Tracking, Coordinated Referral Management, Fee Authorization, Revenue Management utilizing a joint Charge Description Master and Document Management. In addition, the proposal includes an effort to coordinate and establish an information technology data warehouse of demographic and clinical information, which will aid both organizations to maximize both clinical and business improvement opportunities. The most exciting aspect of this proposal is that these products will be designed in such a way that they would be exportable to other VA/DoD collaborative sites.

In addition to the myriad of activities encompassed in our Hawaiian Joint Venture, additional opportunities exist for collaboration in other areas of the Pacific, especially in American Samoa and Guam. In American Samoa, the VA and the Army Reserve 9th Regional Support Command have been discussing construction of a new community based outpatient clinic with Telehealth capabilities at LBJ Medical Center. In collaboration with the

U.S. Navy Hospital on Guam, the VA is working to co-locate their clinic in the new naval hospital being planned. Access issues due to heightened security have been an issue in the past, however the Navy plans to relocate the replacement hospital site so the VA clinic is easily assessable to veterans. Currently, the Naval Hospital Guam provides emergency, ancillary, and intensive care unit support to the existing VA clinic. There are approximately 7,900 eligible veterans on Guam today, with over 1,000 enrollees who actively utilize the VA clinic. These collaborative opportunities are integral to the success of the overall plan of joint venture in the Pacific because both clinics, in Guam and American Samoa, have the potential to provide services to remote minority veteran populations through partnerships with DoD at a savings to the federal government.

Much of what has been accomplished to date is a function of the personal commitment and relationship developed locally. Although a tremendous amount of additional work is required to fully achieve the seamless system we seek, I believe we are in fact the vanguard of the VA/DOD joint venture initiative.

Again, I thank you for the opportunity to share this information about our Joint Venture. Subject to your questions, this concludes my presentation.


FREDERICK J. GARGIULO
Colonel, Medical Service
Chief of Staff
Tripler Army Medical Center/Pacific
Regional Medical Command

**Region 10 Lead Agent Testimony to Capital Asset Realignment
for Enhanced Services (CARES) Commission
Colonel James Meyers, MSC
1 October 2003**

Mister Chairman, members of the CARES Commission, VA Network Leadership, Elected Official Panel, VA Service Organizations representatives and other guests, thank you for this opportunity to provide a TRICARE Region 10 Executive Director response to the CARES draft national plan. It is also an honor for me to speak to you today as you are preparing to shape a future of superior health care for our nation's great and deserving veterans.

Let me first express my appreciation for the wonderful collaboration I have seen between the leaders and staff of the VISN21 and our region's MTFs. It is clear the best interest of the taxpayer's dollar and the best interest of our beneficiaries are well served through the collaborations of our two organizations in this region. In my 21 years of service, I have never seen this level of commitment between the VA and DoD to seek ways, through sharing our resources, to enhance the lives of our beneficiaries.

The focus of my comments today is on the future of VA and DoD sharing under revised financing. The Medical Treatment Facilities(MTF) in our

region will begin a 5-year transition to revised financing starting this next summer. Under this new budgeting mandate, MTF Commanders will receive three types of funding: funds for readiness operations, funds for other operations (like Graduate Medical Education) and a capitated fund allocation based on the MTF's enrolled population. While the details are still being worked out, the basic concept is fixed –an MTF Commander will pay for all care provided to her enrolled population, whether provided in-house, by the health service and support contract or, most importantly for this discussion, provided by any other source to include the VA.

We believe this is one more great reason to collaborate with the VA.

It is easy to see that when a commander must send a capitated beneficiary out to receive care outside the MTF, the VA will likely be a lower cost option than the network or other providers. We do not charge each other our cost of capital...that makes for a competitive advantage when compared to paying the full Champus Maximum Allowable Charge in our local markets.

To enhance service collaboration between the VA and DoD in this new world of budgeting, it may, however, take seed money to set up the most

cost-saving collaborations. We hope that this commission might provide another voice to that need for seed money or “investment dollars” that our MTFs and VISN21 region agree are likely to be needed to fund the more expensive, but in the long term cost-saving, collaborations for the care of our patriot beneficiaries.

Thank you for the opportunity to present our region’s views on the exciting new opportunities we believe are coming as the DoD and VA share even more under our new DoD MTF “revised financing” budget model.

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October 1, 2003

Capital Asset Realignment for Enhanced Services Commission

Members of the Commission;

Thank you for this opportunity to present testimony on the draft plan to close seven Veterans Hospitals throughout the United States. I am here to talk about the possible closure of the Livermore Veteran's Hospital and how this closure would adversely impact the City of Livermore, the Tri-Valley Area and Eastern Alameda County.

The Tri-Valley communities of Livermore, Pleasanton and Dublin recently completed a Human Services Needs Assessment of the Tri-Valley area. The number one identified service gap was access to affordable health care. At the Livermore Veteran's Hospital, the Veterans have a comprehensive on-site medical clinic and nursing home. The draft proposal recommends closing this facility and relocating its services and clients. If this were to occur, the Commission would be removing a vital healthcare service from our community, leaving our veterans to struggle to get the services they so desperately need.

Relocating services and nursing home patients will cause veterans and their families to travel considerable distances in heavy traffic to receive services or visit relatives. From Livermore to the Menlo Park facility is approximately 37 miles, or to put it realistically, one to two hours travel time by car depending on traffic. The Palo Alto hospital is even further away from the Tri-Valley.

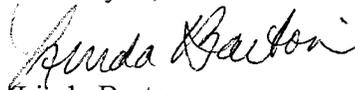
We should not ask veterans, or any person who is ill or frail, to travel long hours to obtain basic medical services; particularly when a facility is already available that is nearby and already providing these services.

~~X~~ Public transportation is not a viable option for the elderly in this case, especially if they are frail or ill. To get to Palo Alto via public transportation requires one to take a 30-45 minute bus ride from Livermore to the Dublin/Pleasanton BART station. The person would ride BART for one hour to the Millbrae station (south of San Francisco), then transfer onto CalTrain for a 40-minute ride to Palo Alto. They would then have to take another bus to the Veterans Nursing home. In order to make it to their medical appointment, a veteran would have to spend over 2 1/2 hours to get to Palo Alto, for an appointment that they now can get to in less than 20 minutes.

If the Livermore Veteran's Hospital were to close, the services that are now provided at this facility would end up being spread throughout the Bay Area, creating undue stress on veterans and their families. It is not beneficial or even humane to split services between different clinics at different locations. We should not expect our veterans to travel long hours to obtain basic, necessary, medical services. Closing the Livermore Veteran's Hospital would create many more public healthcare issues than could possibly be solved by relocating services.

I urge the Commission to keep the Livermore Veteran's Hospital open to best serve our veterans, their families.

Thank you,

A handwritten signature in black ink that reads "Linda Barton". The signature is written in a cursive, flowing style.

Linda Barton
City Manager

Mrs. George Barrie IV

1707 San Vicente Blvd.
Santa Monica, CA 90402-2306

September 29, 2003

Richard E. Larson, Executive Director
CARES Commission, (00CARES)
810 Vermont Avenue NW
Washington, DC 20480

RE: Notice; Draft National Capital Asset Realignment for Enhanced Services (CARES) Plan; 68 Fed. Reg. 50224

Dear Mr. Larson:

I am writing as a member of the Arcadia B. de Baker family. My name is Carolina Winston Barrie. It was Arcadia and Senator Jones who donated the West Los Angeles VA property to the United States Government for the sole purpose that veterans could have a special place of their own to heal from war.

As a result of this donation, on March 2, 1887, an act of Congress was approved to provide for the location and erection of a branch home for disabled volunteer soldiers West of the Rocky Mountains. The Board of Managers of the National Home for Disabled Volunteer Soldiers were authorized, empowered, and directed to locate, establish, construct and *permanently maintain* this branch in West Los Angeles.

Of course, when the land was donated, our family never could have envisioned the West Los Angeles of today and the hundreds of thousands of busy people that travel through the area everyday. We could not have imagined that 85,000 veterans would find their final resting place here in our National Cemetery. Nor could we have anticipated the immense value of the land.

Even if we had been able to foresee the future, our resolve would have been the same. It was not the family's intent then, nor is it now, that the VA land be looked at as "excess" to be bartered for all kinds of material reasons. We are shocked to hear such words used in the C.A.R.E.S. process. This property was donated for the benefit of the veterans themselves those who have made enormous sacrifices so that all of us can live freely in this wonderful country.

The property is filled with lovely old buildings that speak to us of our history. This property was selected because it was warm, balmy and close to the ocean

Richard E. Larson, Executive Director
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September 29, 2003

breezes. It was intended as a permanent home for weary and injured veterans. Veterans from the Civil War, The Spanish-American War and all the wars that followed including Vietnam, Afghanistan and Iraq. At one time the VA housed 45,000 veterans at this location. If cared for properly, it will again be a place where veterans can recover and have time to pause and reflect in thriving gardens or under shady trees.

I believe we must join together to discuss the best use of this property, openly and with the best intent of the veterans and the community in mind.

Sincerely,

A handwritten signature in cursive script that reads "Mrs. George Barrie IV". The signature is written in black ink and is positioned above the typed name.

Mrs. George Barrie IV

cc: Secretary of Veterans Affairs, Anthony Principi

