

August 22, 2003

Everett Alvarez, Jr.
Chairman
CARES Commission

Dear Mr. Alvarez:

Members of the Commission, the Great Plains Chapter, Iowa Chapter, Mid-America Chapter, and Minnesota 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 diseases (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 the 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

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 crisis we encounter as we grown older.

Our local PVA Chapters 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 Great Plains Chapter, Iowa Chapter, Mid-America Chapter, and Minnesota Chapter feels 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.

The Minnesota Chapter of PVA supports the construction of a 30-bed SCI center with plans for an additional 10 beds at a later date at the Minneapolis VAMC. We also believe that this new SCI center must be located on the first floor and constructions plans must be developed to address the issue.

We are pleased to see that VA's recent CARES document calls for the construction of a new 30-to-40 bed SCI Center in Minneapolis.

We also feel that VA must make every effort to plan 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 Great Plains Chapter, Iowa Chapter, Mid-America Chapter, and Minnesota Chapter must speak about the importance of intra-VISN coordination and collaborations 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 meet 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.

Once again the Great Plains Chapter, Iowa Chapter, Mid-America Chapter, and Minnesota Chapter stands ready to assist the Commission in understanding the unique SCI medical needs in our geographical area. If I can be of further assistance please don't hesitate to contact me at (515) 323-7544.

Thank you for listening to our concerns.

Oscar J. Ballard, Sr. NSO
POC between PVA and CARES

**STATEMENT OF
JEROME W. FITZSIMONS
SUPERVISOR, DES MOINES NATIONAL SERVICE OFFICE
OF THE
DISABLED AMERICAN VETERANS
BEFORE THE
CAPITAL ASSETS REALIGNMENT FOR ENHANCED SERVICES COMMISSION
MINNEAPOLIS, MINNESOTA
SEPTEMBER 3, 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 Assets Realignment for Enhanced Services (CARES) Market Plans for VISN 23.

Since it's 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 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, local DAV members are aware of the proposed CARES Market Plans and what the proposed changes would mean for the community and the surrounding area. A number of concerns and benefits have been expressed from Iowa, Minnesota, Nebraska, North Dakota,

and South Dakota. Of particular concern in the restructuring of Capital Assets, is the meeting of the goals VA has to meet the waiting time frames for primary and specialty clinic appointments. These goals have been expressed on numerous occasions and publications however, actual results of meeting this goal in the restructuring proposals, are not seen or identified within any of the VISN areas.

Multiple negative comments have been made, concerning communication between the VA personnel and members of the VISN 23 CARES CAMP teams which included members of the Veterans Service Organizations, individual veterans, concerned citizens, other identified and stakeholders (Camp teams were used to describe the separate states and teams within those states participating in this CARES initiative). There was a lack of communication outside of the VA personnel within the CAMP Teams throughout VISN 23. VA personnel completed preparation of documents for presentation to the VISN 23 commission; however, some issues discussed in the planning process were not included in the final document. Specifically, the Iowa CAMP Teams received information that was not discussed in any meeting, OR recommendations made by members of the Iowa Camp Teams were not included in the document. In addition, uniform planning and review, system wide, were not present in determining the needs during the CARES process.

Concerns expressed:

- All areas of VISN 23 were given the broad stroke of interaction in the process with interested parties (Veterans, VSO's, Stakeholders, etc...). This is an inaccurate indication of participation, as all interested parties did not have opportunity to comment on the completed document prior to submission to the VISN Commission and VA Central Office CARES Committee.
- Users of the VA Medical System have repeatedly stated that they dislike the terminology, describing veterans as stakeholders, clients, etc... (The overwhelming desire by veterans is to be identified and called "veterans, patients, etc...)
- A recommendation was made to transform the Knoxville facility into a comparable relationship as is between the Minneapolis, MN to the St. Cloud facilities, with St. Cloud primarily as a psychiatric facility. There was an immediate response indicating this was infeasible due to cost and access and also that Minnesota would not be able to continue to operate as they are. Knoxville and Des Moines is similar in size and distance to each other as the Minneapolis and St. Cloud facilities are. Failure to disclose this option limited discussion and options to be considered by the Committee and Commission. (CARES report for Minnesota indicated a substantial savings for Minnesota. See Minnesota CARES report to VA Central Office).
- A Cost analysis is not indicated by a majority of the plans presented for review. The facts and figures for nearly all of the VISN's failed to provide how the changes recommended would financially impact the facility, as well as address the issue of access to meet the criteria as set out by the secretary for appointments. (Primary care, Specialty clinics). Users of the VA medical system are NOT convinced, by the presentations provided, that timely access will occur, and that ultimately there will be a dismantling of the medical system in some areas.

- One summary (Minnesota) clearly indicates the states financial inability to provide some services, which will have a negative impact in that state. Other states (Iowa-Knoxville) have provided either no indication of a similar situation or that some negotiation is in process with the state to address possible uses of a given facility. This state however, does not have resources in which to provide the use being sought. (See Knoxville facility on land clearing and use as a Cemetery).
- Cost for demolition of buildings at the Knoxville facility versus savings associated with disconnection of services to unused buildings, was not provided in the CARES analysis recommendations.
- Construction of new facilities or renovation on the Des Moines campus resulted in needing to lease facilities off campus due to inadequate planning. (See domiciliary construction plan and results, VAMC Des Moines, IA).
- The placement of primary clinics off campus (Iowa City) is of such a concern that many veterans believe they will no longer be going to the VA for care. The thoughts expressed indicate that the VA is moving towards an HMO type setting and dismantling of the VA medical system.
- Sale of buildings/land/equipment/etc... was not discussed to ensure that proceeds would be retained by that facility/state in which they were sold.
- Funding considerations for the individual facility, given their unique demographic and geographic situations as a beginning point for measuring financial needs and changes have not been provided. A baseline of general operating need, followed by financial ramifications of change based upon CARES proposals is necessary. The assumptions made in proposals presented indicate a projected ability to handle an increase or change of caseload, without effect upon the funding needs for a given facility in nearly all proposals. Each facility must fully disclose the financial basis for proposals provided. Cost implications to changes as presented through the CARES process are not clear.
- Any efforts that are solely budget driven and that decrease services and limit access for veterans would be a mistake. Of primary concern is the need for the VA to focus on the most important element in the equation, quality health care and the greatest possible timely access to it by our nation's sick and disabled veterans. Any restructuring must ensure that specialized programs designed to meet unique health care needs are not adversely affected and that veterans served by a particular facility are not displaced from receiving necessary health care services.
- Centralizing locations has been noted as an inconvenience to users of the Nebraska VA medical facilities. VAMC Omaha has seen an increase in veterans' visits. Curtailing of services at Grand Island and Lincoln, NE, has resulted in longer waiting times, more complaints from users of the system, as well as added strain on employees. There is an apparent lack of consideration for appropriate staffing levels to meet increased patient load as well as the obvious increased cost or a cost savings by centralizing services.
- Many veterans in **South Dakota** are entitled to VA health care services. We have to make sure accessibility to health care improves. We are from a rural area and many veterans travel anywhere from 100 to 250 miles one-way for treatment. The CARES Commission should be aware of veterans programs and services that are good for veterans on the east coast (New York City) will not be effective or efficient for veterans in South Dakota.

- Forecasting future veteran populations with any accuracy is all but impossible for any timeframe beyond 2 or 3 years. Statistically, information used in planning for timeframes such as used in the CARES plans are well beyond what will actually happen in 5, 10 or even 20 years down the road.
- South Dakota over 2,000 troops were called to active duty since January 1, 2003, not to mention those called up elsewhere within VISN 23. One thing we can be sure of is that veterans are not going away. We feel as long as a single veteran is alive, we have an obligation – a sacred duty – to see to it he/she receives adequate and compassionate health care.
- There is a concern that the CARES Market Plans, which constitutes significant reorganization, will give way to a redefinition of veterans health care within the VISN and throughout the entire VA Healthcare system.
- The Hot Springs VA Medical Center serves rural veterans of Nebraska, South Dakota, and Wyoming. These rural veterans depend on and are well satisfied with the health care at the Hot Springs VAMC. Plus the VAMC provides care for the 120 to 150 residents at the Michael J. Fitzmaurice South Dakota State Veterans Home and the 60 veterans at the VA Domiciliary. We question how this will affect health care to our veterans, if as proposed, Hot Springs VAMC is made an 8-hour operational clinic versus a 24-hour hospital facility.
- Market shares for each area within the VISN and nationally, is noted as a percentage of the veteran population within an area that is enrolled within that area (See August 4, 2003 National Summary). The percentage of veterans used in reports must be consistent and pertinent to needs of a given area. As previously noted, a facility such as South Dakota has 9 percent of the total enrollees for VISN 23, yet the South Dakota facility has a minimum financial need for operations, as well as space to meet the needs of veterans served, that must be considered. Ironically, the Western Wisconsin veteran population is the largest group of users listed in VISN 23. Western Wisconsin users are split in usage to multiple facilities. Furthermore, statistics are not fully explained in their importance to decision making for construction, funding, use of given facilities, etc... Percentages reported under market share do not provide value or pertinence to the recommendations made for the needs of VISN 23.

Positive comments:

- Comprehensive analysis of the Minneapolis/St. Cloud facility use to provide the best possible cost savings and work load between the centers. Options were clear and provided logical decision-making.
- Reorganization of space at VAMC Minneapolis for optimum use is noted as a positive solution for access at this facility.
- Construction of an up-to-date Long Term Care (LTC) facility on the Des Moines grounds provides all services needed at one facility for these unique patients and is cost productive. Renovation of Knoxville LTC facility will cost approximately the same, but combined services with Des Moines is seen as the appropriate action to be taken. It provides a facility that will be up to date and a life span consistent with the needs of veterans and financial responsibility.

- Co-location opportunities at Des Moines and Minneapolis are noted. Cost savings are not provided in the CARES documents; however, other known documentation indicates a substantial savings for VA as well as increased access by veterans to the Veterans Benefits Administration Regional Office in Des Moines, Iowa, which is consistent with the VA's goal of "One VA." (No information is noted for co-location in Minneapolis.) Use of an existing facility at Fort Snelling should continue. Claimants have ease of access to VBA and multiple other agencies as needed.
- We support the establishment of new Community Based Outpatient Clinics (CBOC's) in Iowa; South Dakota; North Dakota; Nebraska and Minnesota.
(Spirit Lake, Shenandoah [share with NE], Cedar Rapids, Marshalltown, Carroll, and Ottumwa). (Wagner, Watertown). (Grand Forks AFB, Devils Lake, Williston, Dickinson [share with S.D.] and Jamestown). (Holdrege, O'Neill, Bellevue [DoD], and Shenandoah [share with Iowa]). (Bemidji). Are sites identified in the Market area summaries.

As the leader of the Veterans Administration, General Omar Bradley stated very well the responsibility of the VA: Were dealing with their problems (veterans), not ours. The Veterans Health Administration must be looked at in a manner that will provide the needed care of those who have already "borne the battle". Even as many pass on daily to our Private, State and National Cemeteries, new veterans are coming into the system daily. As long as there is a military, there will be veterans who need the care that the VA must provide. VA must have a positive, realistic, viable solution for the needs of veterans' care in each and every state of the union. A clear and concise plan must be in place to ensure all the VISN's, all the VA Medical Centers, are on the same page of providing care as mandated by congress. Clear direction from VA Central office must be communicated to each facility and reviewed consistently to ensure compliance with the mission and goal of the Department of Veterans Affairs as well as the mandates of Congress.

In closing, the local DAV members of VISN 23 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.

STATEMENT OF
DENNIS G. FOELL
DIRECTOR, S.D. DIVISION OF VETERANS AFFAIRS
SOUTH DAKOTA DEPARTMENT OF MILITARY AND VETERANS AFFAIRS
BEFORE THE
CARES COMMISSION HEARING
U.S. DEPARTMENT OF VETERANS AFFAIRS

MINNEAPOLIS, MINNESOTA

SEPTEMBER 3, 2003

MR. CHAIRMAN AND MEMBERS OF THE COMMISSION:

On behalf of the veterans of the State of South Dakota and the S.D. Department of Military & Veterans Affairs, I appreciate the opportunity to participate in today's hearing and to share our views on the proposed VISN 23 Capital Asset Realignments for Enhanced Services (CARES) Market Plans.

There is a large segment of the population of South Dakota made up of veterans who are entitled to VA health care services. Because South Dakota is generally a rural area, many veterans must travel as far as 250 plus miles one way in order to receive that care.

I would point out that over 39 percent of the veterans who reside in South Dakota are enrolled in the VA Health Care System. This is the highest enrollment rate for any other state in VISN 23 and I believe the highest percentage of enrolled veterans in any other state in the nation. So, do the veterans of South Dakota want access to the VA Health Care System? The numbers clearly say yes.

We believe that our veterans who want and need primary medical care should not have to travel a long distance to an established VA Medical Center to receive that primary care. That is why we have supported and continue to support the placement of Community Based Outpatient Clinics (CBOCs) in South Dakota and the surrounding states.

The current 12 CBOCs in place and operating in South Dakota have had a significant positive impact on our veterans being able to receive the care that they are entitled to receive. In each instance, as quickly as these clinics were established, the cap, which had been placed on the number of veterans they were created to service, was reached. In many cases, the initial cap was readjusted upward to allow additional veterans access to the clinic.

However, even with these caps in place, we believe that the primary health care the veterans utilizing these clinics are receiving has increased their quality of life. It has also greatly reduced the stress that had previously been placed upon them to drive or find a means to get to one of our three VA medical centers for their primary health care. This coupled with a "more hometown" type care has proven to be very popular with a majority of the veterans who utilize these CBOCs.

The current proposed Market Plan includes provisions for the addition of 3 additional CBOCs in South Dakota. Those are proposed for Watertown, SD, Wagner, SD, and Spirit Lake, IA. Many of our Native American veterans will benefit greatly from the addition of Wagner, SD CBOC. The addition of a CBOC in Watertown, SD will also provide long needed services for veterans in the northeast corner of the state, thus reducing long drives for on-going primary health care.

We fully support the addition of these CBOCs as quickly as possible. While we also realize that VA budget constraints might be used as an excuse to delay the creation of these clinics, we believe that the necessary funding must be found and made available immediately, whether those funds come from within VISN 23 or the VA as a whole.

We have concerns about the Hot Springs VA Medical Center in western South Dakota. This facility serves rural veterans in southwest South Dakota, northeastern Nebraska and eastern Wyoming. Besides the care provided to the rural veterans in these areas, Hot Springs also provides care for the 130 to 150 Residents at the Michael J. Fitzmaurice South Dakota State Veterans Home as well as the patients at the VA Domiciliary in Hot Springs.

The proposal is to modify the level of care this Medical Center provides by converting its acute care beds to conform to a "Critical Access model". Under this model, patients requiring hospitalization beyond 96 hours would be transferred to another VA or to a private sector provider.

Our primary concern is an underlying feeling that perhaps this is simply an initial move to start the process of closing that medical center. If this is the underlying intent, we will, without hesitation, oppose such a move because rather than providing greater service to and easier access to VA Health Care for our veterans, this would drastically reduce their VA Health Care Services. 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.

There is concern by those that treat the mentally ill for conditions including war-related post-traumatic stress disorder, that federal cutbacks will and already have caused "dumping" by the VA. The VA currently uses 38 U.S.C. 1710(h) to shirk their responsibility to pay for the care of the mentally ill; including 100% service connected disabled veterans. When state courts commit veterans to a psychiatric facility other than a VA, the VA refuses to pay, quoting 38 U.S.C. 1710(h) as their reason for denying payment, even for 100% service connected disabled veterans receiving care for their service connected conditions. Further reorganization that would cause some VA facilities to "change its mission" could cause the VA to "dump" its psychiatric patients on state and local facilities.

In closing, we are supportive of the proposed Market Plans as presented in the VISN 23 proposal, as long as those actions enhance the medical services for the veterans of South Dakota. We do not want the CARES Market Plan, which constitutes significant reorganization, to give way to a redefinition of veterans' health care. We value the advocacy of this Commission on behalf of America's veterans and their families. Thank you for the opportunity to present our views on these important proposals.

**TESTIMONY OF THOMAS L. HANSON, VETERANS OF FOREIGN
WARS BEFORE THE CARES COMMISSION – SEPTEMBER 3, 2003
MINNEAPOLIS, MINNESOTA**

First I'd like to thank the Commission for the opportunity to address this hearing this morning. Our State Commander, Steven Van Bergen has also asked that I offer his thank you to the Commission for this occasion to offer testimony.

The concerns we of the Veterans of Foreign Wars share with you this morning deal primarily with the lack of security for the future of the Veterans Health Administration, or more so the lack of pledges for the future for the Veterans Integrated Service Network (VISN) 23.

The proposed relocation of acute medicine for patients at the St. Cloud, MN DVAMC to Minneapolis and contracts within the local community had already been accomplished some time ago and I understand it seems to be working reasonably well. However, it certainly is going to be an inconvenience to the patients that use that facility to have to travel the considerable distance of 90 miles from St. Cloud to Minneapolis for some of their acute medical needs. We believe that St. Cloud should be able to offer its patients some ambulatory day surgical procedures. We find it difficult to understand why a veteran that requires a procedure as minor as arthroscopic surgery should have to travel that distance to have his needs met. Our recommendations would be to keep as an extensive day surgery program in St. Cloud as possible.

We have additional concerns regarding the long-term health care needs of our veterans. Mostly in the long-term nursing care units. Obviously, the veteran population seeking help with their health care needs are not getting younger. The need for long-term nursing beds will increase. We would like to see some reassurances that the current number of beds will not be reduced, but rather a vision for an increased number in the future. It appears that the present CARES plan is short on perspective needs for the "distant" future in the way of offering any extended care expansion other than Iowa and Nebraska. Minnesota veterans in need of extended care need those beds in this state, not Iowa or Nebraska.

Our concerns are raised, as well, by the need for an expanded number of Community Based Outpatient Clinics (CBOC.) With a continual reduction in the services provided by the VA facilities themselves, it becomes imperative that the VA attempt to meet the medical needs of the veterans they serve by the establishment of more CBOC's. The current plans do call for more of these contracts through the year 2005. However, the list is too short and the proposed expansions are not adequate to meet the needs we believe the numbers represent. The two Minnesota facilities have virtually put a moratorium on any further CBOC's being established. We believe that the move of the CARES Commission ought to be a recommendation for an expansion for this way of dealing with the health care needs of veterans beyond those proposed in the current plan.

We appreciate the recommendations of the Commission to develop a Spinal Cord Injury unit at the Minneapolis DVAMC. There is a need for this type of specialty care in an area as large as that served by the Minneapolis facility. We represent a large number of veterans in this area with spinal cord injuries that would benefit greatly from such a specialized unit.

We also concur with the recommendation of the Commission that there is a high priority need for a co-location of the VA Regional Office in St. Paul and the DVA Medical Center in Minneapolis. The VA is paying the General Services Administration (GSA) a large amount of money each month for rental of space to accommodate the needs for the Regional Office, the Debt Management Center and the Pension Center. With the St. Paul office operating as a regional loan center for several states in the central United States, and the Debt Management Center collecting debts for the entire country, it is apparent that there will be additional space needs for these operations. As well, the Pension Center is in its infancy and may very well be underestimating their space needs now and into the future.

Again, I'd like to thank the Commission for the time allowed the VFW for these remarks and trust that our recommendations here and those provided by our Organization representatives around the country will be given consideration.

CARES Commission
September 2, 2003
VA Medical Center, Minneapolis, MN

THANK YOU FOR ALLOWING ME TO COMMENT ON THE CARES PROCESS. I REPRESENT, AS STATE COMMISSIONER, THE VETERANS OF NORTH DAKOTA.

OUR CONCERN FOR THE FUTURE IS THE AVAILABILITY OF CARE FOR VETERANS.

ALTHOUGH NORTH DAKOTA MAY NOT HAVE THE HIGHEST POPULATION VOLUME, WHY SHOULD THE VETERAN FARMER HAVE LESS ACCESS TO THE V.A. HEALTHCARE THAN THE VETERAN IN THE LARGE METROPOLITAN CITY?

MY EXPERIENCE REMINDS ME THAT V.A. INITIATIVES ARE, IN MOST CASES, FOCUSED ON HIGH POPULATION AREAS.

THE PLAN FORECASTS THAT THE PROPORTION OF NORTH DAKOTA VETERANS WHO MEET THE ACCESS DERIVING TIME GUIDELINES FOR PRIMARY CARE WILL REMAIN AT 37 PERCENT THROUGH 2022. THAT IS ABOUT THE WORST IN THE NATION.

OUR PLAN LISTED COMMUNITY BASED OUTPATIENT CLINICS IN GRAND FORKS, JAMESTOWN, DEVIL LAKES, DICKINSON AND WILLISTON. IT IS IMPERATIVE THAT OUR VETERANS IN WESTERN NORTH DAKOTA OBTAIN ACCESS TO HEALTHCARE, OUR ONE V.A. MEDICAL CENTER IS LOCATED IN EASTERN NORTH DAKOTA, BORDERING MINNESOTA.

I THANK YOU FOR THE OPPORTUNITY TO BE A PART OF THIS PROCESS THAT WILL DICTATE HEALTHCARE FOR OUR VETERANS IN THE FUTURE YEARS.

Ray Harkema
Commissioner
North Dakota Department
of Veterans Affairs

**STATEMENT OF
DANIEL LUDWIG, PAST NATIONAL COMMANDER
THE AMERICAN LEGION
BEFORE THE
CAPITAL ASSET REALIGNMENT FOR ENHANCED SERVICES
(CARES) COMMISSION
ON
THE NATIONAL CARES PLAN
SEPTEMBER 3, 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) 23. 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 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 23-MINNESOTA, NORTH DAKOTA AND SOUT DAKOTA

Minnesota

Minnesota has a veteran population of over 450,000 with enrollees numbering over 90,000.

Primary care access is a problem in this market. The Draft National CARES Plan (DNP) addresses this by proposing the establishment of four new Community Based Outpatient Clinics (CBOCs) throughout the state. This is a positive step in the right direction and we are pleased to see these CBOCs are part of this proposal, as they are sorely needed. However, every effort should be made to staff these CBOCs by VA personnel. This will alleviate the miscommunication that can occur when non-VA staff is caring for veterans. Non-VA staff is not familiar with the VA system and many times cannot answer a veteran's question about a VA benefit that is not related to the clinic.

The DNP proposes to contract care in the community to improve access to hospital care. The American Legion believes it is incumbent upon VA to ensure that all avenues of providing care within VA are exhausted before contracting veterans' care. We believe this should be used as a last resort.

Outpatient Specialty Care is projected to grow in this market. The DNP proposes to contract out high volume, less complicated procedures in the community to meet this demand. In addition, there will be some renovation done at the VA Medical Center in Minneapolis.

The DNP proposes to relocate acute medicine to the Minneapolis VAMC and contract inpatient care in the local community. The American Legion does not support this proposal under this plan. Why are beds being moved out of the community, only to contract in the community for the same service that had been provided by VA? St. Cloud provides excellent mental health services. In addition, there is a nursing home, a domiciliary, and outpatient care being provided to the veterans in this area. Another concern is The American Legion does not believe veterans should be subjected to a 70-mile drive, between St. Cloud and Minneapolis, through three of the nastiest intersections and then add a Minnesota winter into the mix, and you have a very dangerous situation. Veterans will not make that drive and they shouldn't have to.

North Dakota

This is a very rural market that is serviced by one VA Medical Center located in Fargo. The veteran population is over 60,000 with 20,400 veterans enrolled, giving North Dakota one of the highest market shares in the country at 34%.

The VISN Market Plan submitted in April proposed the establishment of six new CBOCs throughout this market. However, the DNP did not include any of these CBOCs, effectively dismissing the needs of the veterans located in this historically underserved area. The American Legion is very disappointed and remains concerned with the lack of access to VA health care in this market.

In the Bismarck and Minot areas, the DNP proposes to contract out tertiary care needs in the community. One of our primary concerns with this is whether the community is capable of providing quality care and willing to absorb the veteran population. Has the VISN researched the capabilities of the local medical community?

South Dakota

This market has a veteran population of over 78,000 with over 31,000 enrollees giving it the highest market share in the country of 40%.

The DNP proposes to convert the Hot Springs division of the VA Black Hills Health Care System (HCS) to a Critical Access Hospital (CAH). VA has not developed its own set of criteria for what a functioning CAH is. They are currently using, somewhat, the Centers for Medicare and Medicaid Services (CMS) which is:

- Must be located more than 35 miles from the nearest hospital;
- Must be deemed by the state to be a “necessary provider”;
- Must have no more than 15 acute beds (with up to 25 beds total);
- Cannot have length of stays (LOS) greater than 96 hours (except respite/hospice);
- Must be part of a network of hospitals;
- May use physician extenders (Nurse Practitioners or Physician’s Assistants or registered Nurse Midwives) with physicians available on call.

Since a CAH is a new concept, The American Legion does not support nor do we oppose this concept. We do support keeping the Hot Springs facility open, as it is a very important facility to the veterans that it currently serves. We will be monitoring the implementation phase of CARES and in this case, the change in mission scope designated for Hot Springs. The change in scope of mission, to us, is just one step short of closure. We will be watching closely.

Thank you for the opportunity to be here today.

CARES TESTIMONY
Jeffrey L. Olson
Commissioner of Veterans Affairs
State of Minnesota
September 3, 2003
Minneapolis, MN

Mister Chairman and Members of the Capital Asset Realignment for Enhanced Services (CARES) Commission. I would like to thank you for the time and effort you have given on this very important commission; the recommendations that you make will affect the delivery of service to veterans throughout VISN 23 and the entire United States for many years.

I appreciate the opportunity to present my views on the CARES initiative as it relates to Minnesota's 450,000 veterans, many of whom are being treated or are waiting for care by United States Department of Veterans Affairs Medical Centers and Community Based Outpatient Clinic's. In preparing this testimony I have gathered comments from the professionals in our 87 counties who work diligently at the local level by assisting veterans needing benefits and services from the USDVA medical centers and regional offices – our County Veterans Service Officers's. I have also discussed the process with representatives of the many veterans service organizations in Minnesota.

I would like to state for the record that the employees of these USDVA facilities are dedicated, hard-working and skilled individuals who provide excellent care for our deserving veterans who have been admitted to the healthcare system. The primary blockade these dedicated employees face in their attempts to provide healthcare to even more veterans, many of whom remain on lengthy waiting lists, is the shortfall in funding.

The CARES initiative has been made necessary by the shift from inpatient to outpatient care in our nation's healthcare system. I suspect everyone in this room remembers that just a few short years ago a person would spend a number of days in the hospital for surgeries and other medical procedures that are being performed today in day surgeries with an immediate release home. The Minneapolis Medical Center is proof positive of this trend, having experienced a 54% increase in outpatient visits over the past 10 federal fiscal years. I believe when the current fiscal year is complete we will again see an increase in these numbers. These changes have significantly reduced the need for inpatient space and have resulted in many of the buildings on our VAMC campuses being vacated. The expense of maintaining these under-utilized buildings was highlighted in a report that was released shortly before the CARES initiative was established.

VISN 23 - PROCESS

I believe that the process followed in VISN 23 to share information related to CARES and to gather feedback has included the primary stakeholders representing Minnesota's veterans and the employees who provide healthcare services to these veterans. The shortening of the original timelines for Phase II made it difficult for some to attend all the meetings and to absorb the multitude of facts, figures and documents disseminated. However, everyone did their best to produce a quality end product.

Problems with the model utilized to predict the needs for long term care and mental health care future needs resulted in the omission of these important services in the plan. I understand this will be addressed in the next phase of CARES.

At this time, I would like to share the concerns and recommendations I have for your consideration in the future.

CONCERNS AND RECOMMENDATIONS

- 1. A comprehensive review of long-term care and mental health care needs must be completed in the next phase of CARES. Without this inclusion the process is seriously flawed.**
- 2. There are no funds provided for the implementation of the CARES initiatives. Adequate funding must be provided from new resources for all initiatives. Current resources provided, while increasing, still do not meet current demand and we must remember that significant waiting lists continue to exist. Even a program as laudable as the Spinal Cord Injury Center, as recommended by VA Central Office, must be fully funded with new resources to ensure that no additional waiting lines or reduction in services result from its implementation.**

I believe this recommendation would be consistent with those included in the report of the President's Task Force to Improve Health Care Delivery for Our Nation's Veterans.

- 3. The new (4) Community Based Outpatient Clinics (CBOCs) are well thought out and sorely needed. The successes at the CBOCs already operating in Minnesota are proof positive of their need and excellence.**

I would like to recommend that these new clinics be staffed with VA personnel. Even though it is only anecdotal evidence I would submit to you that the verbal complaints we receive are significantly higher at contract facilities. Most often these complaints are related to the lack of knowledge that the contract staff have of VA rules and regulations, not the quality of health care delivered. The confusion created can be detrimental to the total delivery of health care to the veteran.

- 4. The shift of acute care from St. Cloud VAMC to Minneapolis VAMC is also of concern even though it may effect a small number of veterans. We know that one of the reasons CBOCs are so popular is the fact that many of our veterans are elderly and will not make the drive to Minneapolis to receive their health care. Unless there is some plan for providing transportation for these veterans, they are unlikely to make the trip and will thus be denied their right to health care.**
- 5. At one time, the draft plan included a closure date for the CBOC in Montevideo. That date no longer appears in the plan but it must be discussed as it has created significant concern for the veterans receiving care at that CBOC and the community that worked so hard to create a solid partnership with the USDVA in the creation of the facility.**

I would suggest that performance measures of CBOC success be based upon the utilization of the facility by veterans, not just a review of projected demographic change in the area. Also, any discussion of closure needs to include the community prior to being released, even in a draft report.

- 6. In addition to the comments offered in item 3 related to VA staffed CBOCs versus Contract CBOCs, I would recommend performance measures are developed which provide a comparison of the costs of health care services delivered in each system.**
- 7. Once this plan is completed, has been shared with the Stakeholders, we must stand united to ensure that all aspects of the plan are implemented. I was struck by the many references in the “President’s Task Force” report to the recommendations made by previous task forces and commissions that were never implemented or only partially implemented.**

We can not allow the CARES plan to become simply a building demolition process as there are many aspects of the plan which plot a very positive course of action for our nation's health care delivery system for veterans.

Mister Chairman and Members, that concludes my testimony. On behalf of Governor Pawlenty, myself and the Veterans of Minnesota I thank you for your service to this great nation.



Jim Doyle, Governor
Raymond G. Boland, Secretary

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TESTIMONY

OF

JOHN A. SCOCOS, DEPUTY SECRETARY
WISCONSIN DEPARTMENT OF VETERANS AFFAIRS

BEFORE THE
VA CARES COMMISSION HEARING
ON
THE DRAFT NATIONAL CARES PLAN
AND
VETERANS INTEGRATED SERVICE NETWORK (VISN) 23

AT THE
MINNEAPOLIS VA MEDICAL CENTER
SEPTEMBER 3, 2003

Thank you for the opportunity to comment on the CARES process and how it will impact Wisconsin veterans. Fifteen northwestern Wisconsin counties are in the Minneapolis VA Medical Center's (VAMC) catchment area – veterans from those counties primarily look to VISN 23 VA facilities for health care services. Currently, facilities in VISN 23 that service Wisconsin veterans are the Minneapolis VAMC, the Chippewa Falls Community-Based Outpatient Clinic (CBOC) and the Twin Ports Satellite Clinic in Superior, Wisconsin.

In the CARES plan for VISN 23, there are three proposals we would like to comment on. The first is to add a CBOC in northwestern Wisconsin where distances to care are excessive. The site recommended is Rice Lake. However, the intent is to contract with a provider (or providers) to offer services to veterans in several communities in that area, such as Hayward. The Wisconsin Department of Veterans Affairs (WDVA) supports this plan of contracting for services in several communities wholeheartedly. Additional CBOC coverage will provide improved access for many more entitled veterans who live too far from a VA facility to realistically seek care from VA. Access, as we all know, is not just about capacity, but also about distance.

Second, the VISN 23 plan proposes the Minneapolis VAMC develop a contractual relationship with hospitals in the Duluth, Minnesota/Superior, Wisconsin area for provision of inpatient medical and inpatient surgical bed-days for those cases where access to Minneapolis is not feasible. While it is not clear under what circumstances such contracted services would be used, WDVA endorses this concept as it also will improve access.

Third, the plan proposes that VA facilities contract for a percentage of high volume/low cost/low complexity specialty procedures in the community – procedures such as colonoscopy and flexible sigmoidoscopy – where VA facilities lack sufficient staff to handle the demand. While the plan suggests this for the Minnesota market, similar services should be sought in western Wisconsin from area physicians who would be

willing to perform such procedures. While the numbers would likely be relatively small, if veterans in the metropolitan Minneapolis market are having difficulty getting such procedures done, the problem also exists in rural northwestern Wisconsin. WDVA would endorse such a modification to the plan.

Overall, the proposed VISN 23 planning initiatives address the most serious shortcomings that exist for veterans in western Wisconsin if these suggested plans become reality.

There is an important area not addressed in the VISN 23 planning model that we believe needs to be mentioned. This is long-term care. We believe the CARES Commission should address this issue in its final report. The potential exists for continued expansion of the federal/state partnership programs - the state home construction grant and the state home per diem. There is no veterans home in the Wisconsin counties in the Minnesota Market. The long-term care needs for veterans in the northwest corner of our state are not being adequately met. Currently all Wisconsin long-term care links with USDVA are through VISN 12. Expansion of the state home program to northwest Wisconsin could represent a win-win situation for both partners – WDVA and VISN 23. Wisconsin currently operates a health care facility in Chippewa Falls, the Northern Wisconsin Center of the Developmentally Disabled (NWC), which is currently being downsized. With this downsizing effort, state infrastructure, both buildings and land, will become available. We are developing a veterans home in southeastern Wisconsin, also an underserved area, where buildings and land on the Southern Wisconsin Center for the Developmentally Disabled came available as they downsized. A similar initiative could occur at NWC. This campus is also an ideal site for an expanded CBOC operation in Chippewa Falls. We believe that significant savings could be realized through a collaborative initiative, one that could provide nursing home care services, assisted living, transitional housing for homeless veterans, primary care and adult day health care. We recommend this course of action be considered.

**Testimony, John A. Scocos, Deputy Secretary
Wisconsin Department of Veterans Affairs**

That concludes my remarks. Thank you again for the opportunity to share our thoughts on the proposed VISN 23 plan for the Minnesota and northwestern Wisconsin market.

STATEMENT OF
GENE A. MURPHY
PAST NATIONAL COMMANDER
OF THE
DISABLED AMERICAN VETERANS
BEFORE THE
CAPITAL ASSETS REALIGNMENT FOR ENHANCED SERVICES COMMISSION
MINNEAPOLIS, MINNESOTA
SEPTEMBER 3, 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 Assets Realignment for Enhanced Services (CARES) Market Plan for this area in VISN 23.

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, local DAV members are aware of the proposed CARES Market Plan and what the proposed changes would mean for the community and the surrounding area.

Our concerns for South Dakota include the following:

MARKET AREA AND VETERANS POPULATION:

Many veterans in South Dakota are entitled to VA health care services. We have to make sure accessibility to health care improves. We are from a rural area and many veterans travel anywhere from 100 to 250 miles one-way for treatment. The CARES Commission should be aware of veterans programs and services that are good for veterans on the east coast (New York City) will not be effective or efficient for veterans in South Dakota.

We feel that forecasting future veteran populations with any accuracy is all but impossible. Currently, thousands of Guard and Reserve troops are being called to active duty every month. Who knows the number of new veterans that will be created as we continue to fight the war on terrorism. In South Dakota over 2,000 troops were called to active duty since January 1, 2003. One thing we can be sure of is that veterans are not going away. We feel as long as a single veteran is alive, we have an obligation – a sacred duty – to see to it he/she receives adequate and compassionate health care.

The Department of Veterans Affairs (VA) has over time changed eligibility requirements and denied admission to veterans based upon means testing or veterans category. Some veterans have been confused and lost trust in the VA system.

We do not want the CARES Market Plan, which constitutes significant reorganization, to give way to a redefinition of veterans health care.

We feel that rural veterans who want and need medical care should not have to travel to a major urban center (Minneapolis, MN) because the VA has downsized or closed the local VA Medical Center. Many of the facilities that are targeted to lose the most are those in areas that are already medically underserved. Great distances for care constitutes a real form of geographic discrimination.

VA must consider Priority 7 veterans in the allocation process in some manner or fashion. South Dakota has a large number of Priority 7 veterans (7a=764 and 7c=24,278 of 53,419 enrolled veterans as of 09-30-03) who have entered the VA system over the last several years are primarily seeking prescription drug benefits and limited primary care services.

SMALL FACILITY ISSUE:

We are concerned about the Hot Springs VA Medical Center in western South Dakota. The VA underutilization of the Hot Springs VAMC by closing programs/services and beds is because of funding. Doctors and staff were coerced into dismissing inpatients based upon clinic guidelines, diagnostic regulated guidelines (DRGs), and hospital policy

rather than the condition of the patient. The leadership was more concerned about the length of stay than the needs of our veterans. Inpatient beds have been eliminated and wards consolidated to “maximize efficiencies.” This means space was not being utilized.

The Hot Springs VA Medical Center serves rural veterans of Nebraska, South Dakota, and Wyoming. These rural veterans depend on and are well satisfied with the health care at the Hot Springs VAMC. Plus the VAMC provide care for the 120 to 150 residents at the Michael J. Fitzmaurice South Dakota State Veterans Home and the 60 veterans at the VA Domiciliary. We question how this will be affecting health care to our veterans when Hot Springs VAMC is made an 8-hour operational clinic versus a 24-hour hospital facility.

ACCESS IMPROVEMENTS:

We do agree with the placement of new Community Based Outpatient Clinics (CBOCs) at Spirit Lake, IA; Wagner, SD; and Watertown, SD. We had concerns in the past when CBOCs in Aberdeen, Pierre, Rapid City, and Sioux City had been capped with area veterans waiting to be enrolled in the local CBOCs or traveling 100 to 250 miles one way to receive health care. The caps came about because of funding.

We have concerns with access to health care at the Sioux Falls VA Medical Center. As of May 2003 the VAMC had over 3,000 veterans enrolled waiting to see their first doctor’s appointment, plus 120 new enrollment veterans per month. The leadership of VISN 23 and Sioux Falls VAMC has stated that the waiting list will be resolved by September 30, 2003. We hope they’re not playing games with figures and these veterans will be provided health care by the end of the fiscal year.

The DAV feel any efforts that are solely budget driven and that decrease services and limit access for veterans would be a mistake. Of primary concern to the DAV is the need for the VA to focus on the most important element in the equation, quality health care and the greatest possible timely access to it by our nation’s sick and disabled veterans. Any restructuring must ensure that specialized programs designed to meet unique health care needs are not adversely affected and that veterans served by a particular facility are not displaced from receiving necessary health care services.

Access to priority health care for our nation’s service-connected disabled veterans has been seriously eroded over the years due to insufficient health care funding. The VA health care system is under intense pressure to improve access to care and reduce waiting times, while maintaining the highest standards for quality care. However, the VA admits it has reached capacity at many health care facilities as a result of rising costs for health care and increased demand for medical services. The cumulative efforts of insufficient funding have now resulted in the rationing of care and swelling waiting lists of veterans seeking treatment at VA facilities.

The DAV feels solving this problem will require a fundamental change in the way government funding is provided for the VA medical care system. Federal legislation

would be required to shift VA medical care from a discretionary to a mandatory funding program.

Making veterans health care mandatory would eliminate the year-to-year uncertainty about resources that has prevented the VA from being able to adequately plan for and meet the needs of veterans seeking treatment.

LONG-TERM CARE:

We have concerns how the VA will address the issues of long-term care. VA continues to struggle with the issue of long-term care. With a constrained budget, VA must weigh the needs of an aging veteran population against the high cost of providing inpatient long-term nursing home care. VA attempted to address the issue of long-term care needs in its Capital Asset Realignment for Enhanced Services (CARES) initiative. Unfortunately, this important but complex issue has been currently put aside during this critical phase of CARES. According to GAO, the initial data and projections for nursing home needs exceeded VA's current nursing home capacity and were not consistent with VA's policy on long-term care. VA has indicated it is currently rethinking its policy on long-term care and plans to develop a separate process to provide projections for nursing home and community-based services. Additionally, it has plans to include long-term care needs in its strategic planning initiatives.

Although we must wait for the official GAO document before we can comment on these findings, we do have concerns that VA is not meeting the needs of veterans requiring extended care services.

POSSIBLE DUMPING BY V.A. TO STATE OR LOCAL AGENCIES

There is concern by those that treat the mentally ill for conditions including war-related post-traumatic stress disorder that federal cutbacks will and already have caused "dumping" by the V.A.

The V.A. currently uses 38 U.S.C. 1710(h) to shirk their responsibility to pay for the care of the mentally ill; including 100% service connected disabled veterans. When state courts commit veterans to a psychiatric facility other than a V.A., the V.A. refuses to pay, quoting 38 U.S.C. 1710(h) as their reason for denying payment, even for 100% service connected disabled veterans receiving care for their service connected conditions.

Further reorganization that would cause some V.A. facilities to "change its mission" could cause the V.A. to "dump" its psychiatric patients on state and local facilities.

SPINAL CORD INJURY:

We feel that VISN 23 should have a Spinal Cord Injury (SCI) Treatment Center to be located in the center of the VISN to be at the Sioux Falls VA Medical Center. This would

provide SCI health care close to the veterans home. Plus the VA would allow SCI veterans the option of referral to existing SCIVs if desired.

It is absolutely crucial that veterans be consulted and kept well informed throughout the CARES process. We as service-connected veterans who rely on the VA for medical care must be an important part of the decision process.

We are looking to CARES to provide a framework for the future of VA health care that is fair, based on consistent data, and identifies not only areas of expansion, but also of opportunities to better use existing resources.

The CARES process should have one clear charge, to create a brighter future for VA health care by making better use of resources to provide more effective health care for our nation's veterans.

In closing, the local DAV members of VISN 23 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.