

STATEMENT FOR THE RECORD

OF

**Vietnam Veterans of America
Tennessee State Council**

Submitted by

**Charlie Richardson
President
VVA Tennessee State Council**

Before the

Cares Commission

Regarding

Draft National Cares Plans

Presented At

**Nashville Convention Center
VISN 9
Nashville, Tennessee**

September 10, 2003

Good morning, my name is Charlie Richardson. I am the President of the Vietnam Veterans of America (VVA) Tennessee State Council. Thank you for the opportunity to testify today regarding the Draft National CARES Plan. I will comment on the plans regarding delivery of health care to veterans who utilize Veterans Health Administration (VHA) facilities in VISN 9.

The concept of CARES—to assess VHA’s current capital assets and determine its future needs—is a worthy goal. No one wants to see money being wasted on the maintenance of old, outmoded, and in some cases, unused buildings. That is money that could be better spent in providing health care to veterans. As you know, the President’s Task Force to Improve Health Care Delivery for Our Nation’s Veterans recently pointed out the “mismatch” between demand and funding that has resulted in lengthy waiting times for veterans who come to VA for care. In fact, last January, the Secretary for Veterans Affairs curtailed the enrollment of Priority 8 veterans because of the long waiting lines. Although VA has consistently referred to these veterans as “higher income veterans”, the criteria VA uses for that determination includes that used by HUD to determine eligibility for housing assistance. Many veterans in Tennessee who fall into the Priority 8 category are not much above that level and are in need of the access to the VA health care that Congress promised in 1996.

Veterans in Tennessee are concerned about the intent of the CARE process. Our concern, and our confusion, stems in part from conflicting pronouncements from VA regarding the enrollment decision made last January. While veterans were originally told that the reason for curtailing Priority 8 enrollment was due to lack of funds to meet the demand for care, VA now states in a publication from the Office of Public Affairs (Qs and As, under Secretary’s Draft National CARES Plan, July 2003) that the “temporarily suspended enrollment” of Priority 8s did not impact at all on the forecasted bed need and “the impact on the projected number of outpatient visits was less than 1 percent of the entire system. When this is broken down to the Network, market and facility levels, the impact is negligible.” We would welcome clarification on this matter.

The Vietnam Veterans of America, Tennessee State Council has additional concerns regarding the draft CARES plan. Among other things, we find it is very disjointed in its presentation and non-specific regarding where and how

certain services will be provided. While we realize this plan focuses on capital assets, it is difficult for the veterans of Tennessee to envision what the adoption of this plan would mean to them.

We wish to express our concern about the following items:

- Although additional SCI long-term care beds are being added at Memphis and a new Blind Rehabilitation Center will be placed in Biloxi, patients in VISN 9 usually must travel long distances from home for specialized services such as blind rehabilitation and spinal cord injury services. This imposes additional difficulties for family members who need to be included in the veteran's rehabilitation while continuing to work, care for other family members, and meet their other responsibilities. We encourage VHA to develop the use of tele-medicine/tele-home care in order to include family members in the rehabilitation process.
- While mention is made of expanding existing outpatient clinics to include mental health services, it is unclear how VA will be able to provide every CBOC with mental health clinicians who have expertise in the treatment of all the various conditions encompassed under the term "mental health". We are especially concerned about the provision of appropriate care for PTSD and military sexual trauma. It concerns us when veterans at the Chattanooga Outpatient Clinic who have been in the system and have waited six months to see their primary care physician, have their appointment cancelled and rescheduled some six months later.
- The plan calls for increasing the use of community contract services. While this may have the benefit of providing care closer to the veteran's home, we question how VA plans to educate numerous contract providers on the issues particular to veterans—PTSD, military sexual trauma, ionizing radiation, exposure to environmental agents, and other.
- The failure to include inpatient and outpatient mental health care, domiciliary care and long-term care in the planning process before

determining, even on a preliminary basis, what space is considered expendable.

We applaud the following ideas that are put forth, although we would like to see more specifics about their feasibility and timeline for implementation:

- Enhanced-use leases for assisted living facilities.
- Use of tele-medicine to improve access to specialty care.

We were pleased to learn the Alvin York campus in Murfreesboro will be adding 20 new beds and will begin ambulatory surgery at this campus.

We were also pleased to hear of the new prescription program where a veteran can bring in the prescription from their outside physician to be filled.

Mr. Chairman, VVA's founding principle is "Never again will one generation of veterans abandon another." We do not want VA to abandon programs which are vital to the care and treatment of the men and women who are returning home from the war in Iraq and to those who served this country in the past.

In conclusion, we feel that decisions made within the context of the proposed Draft National CARES Plan must be made with caution, and with a full understanding of what unintended consequences may result.

Mr. Chairman, thank you for the opportunity to submit our statement for the record on behalf of Vietnam Veterans of America (VVA) Tennessee State Council.

Vietnam Veterans of America
Tennessee State Council

Nashville Convention Center
September 10, 2003

**STATEMENT OF
HOWARD LEE
THE AMERICAN LEGION
BEFORE THE
CAPITAL ASSET REALIGNMENT FOR ENHANCED SERVICES
(CARES) COMMISSION
ON
THE NATIONAL CARES PLAN**

SEPTEMBER 10, 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) 9. 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 9-CENTRAL, EASTERN, AND WESTERN MARKETS

Central Market

The Central Market is comprised of 75 counties located in the States of Tennessee, Kentucky and Georgia. The VA Tennessee Valley Healthcare System, located in Nashville, is the VA Medical Center that services the area. There are over 72,000 veterans residing in this market. The CARES initiative identified significant gaps in both primary care and specialty care. The original market plan submitted by the VISN in

April 2003 proposed the establishment of additional sites of care to address this problem. However, the Draft National Plan (DNP) did not recommend the placement of any new primary care sites for this market. The CARES standard is 70%, and this market clearly falls short with only 60% of the veterans having access to primary care. The American Legion is concerned that the needs of the veterans are not being met.

Campus Realignment/Consolidation of Services

The Nashville and Murfreesboro VA facilities are about 40 miles apart with two different distinct missions serving different populations. These facilities have been consolidating services for several years. The DNP proposes to maintain both facilities while continuing to consolidate services to compliment each other's mission. The American Legion supports maintaining both facilities.

Outpatient Services

The plan proposes to use telemedicine and community contracts to meet the increase in demand in outpatient specialty services. While telemedicine is the logical next step for VA as far as treatment is concerned, the use of it is not widespread and it is an expensive program to run. Additionally, The American Legion believes the use of community contracts to meet the special needs of veterans should be avoided and only used as a last resort.

Inpatient Services

Again, the DNP will meet the increase in inpatient medicine services in this market by utilizing, among other things, community contracts. The American Legion cautions VA on the wholesale use of contracting out care to meet the demand in the future. Even if it is only a temporary measure, it has the potential to quickly become the norm and not the exception. VA is a provider of care, not a purchaser, and The American Legion will remain vigilant in monitoring the use of contracted care.

Eastern Market

The Eastern Market is comprised of 34 counties located in the States of Tennessee, Virginia, Kentucky, and North Carolina. This market relies upon the services of the James H. Quillen VA Medical Center in Mountain Home, Tennessee. This market is expected to see significant growth in primary care, specialty care, and mental health through Fiscal Year (FY) 2012 and 2022. Currently, only 51% of the veterans are within the prescribed CARES standards for access to primary care. While the original Market Plan submitted by the VISN proposed the establishment of two outpatient care sites in this market, the DNP does not address the issue. The American Legion is concerned that nearly 20% of the veteran population will not have access to care. The DNP basically ignores its own standards and as a result, many veterans are left behind.

Collaboration

The National Cemetery Administration is exploring the possibility of expanding the national cemetery at Mountain Home. The American Legion does not oppose this collaboration. Many of the VA National Cemeteries are quickly filling up and running out of room. It is important to honor those who served with a final resting place everyone can be proud of.

Western Market

This market is comprised of 53 counties located in Western Tennessee, Northern Mississippi, and Eastern Arkansas. This is rural market, with only one population base located in Memphis. The lone VA Medical Center to service this market is also in Memphis. The CARES process identified significant gaps in access to primary care, specialty care, inpatient beds, mental health care and long-term care beds for Spinal Cord Injury (SCI). To address the shortfall in access, the VISN proposed the establishment of 16 Community Based Outpatient Clinics (CBOCs) in spread throughout the market. However, the DNP did not propose the establishment of any CBOCs for the entire VISN.

Also, because it is a rural market, inpatient services and the availability of sub-specialty care is spotty. The American Legion notes that this was not addressed to any length in the DNP and we are concerned that once again, veterans needs are not being addressed.

Thank you for the opportunity to be here today.

VETERANS OF FOREIGN WARS

OF THE UNITED STATES



STATEMENT OF

JOHN FURGESS
SENIOR VICE COMMANDER-IN-CHIEF
VETERANS OF FOREIGN WARS OF THE UNITED STATES

BEFORE THE

CARES COMMISSION FIELD HEARING

WITH RESPECT TO

VISN 9 CARES STRATEGY

NASHVILLE, TN

SEPTEMBER 5, 2003

MR. CHAIRMAN AND MEMBERS OF THE COMMISSION:

On behalf of the 2.6 million members of the Veterans of Foreign Wars of the United States (VFW) and our Ladies Auxiliary and especially my 27,000 fellow VFW members from the great state of Tennessee, I would like to ~~take this opportunity to~~ thank you for the opportunity to appear before you today regarding the future of veterans health care delivery in Tennessee. Perhaps no other topic, other than adequate funding, is as important.

We recognize that the location and mission of some VA facilities may need to change to improve veterans' access; to allow more resources to be devoted to medical care, rather than the upkeep of inefficient buildings and to adjust to modern methods of health care service delivery. Therefore, the VFW is supportive of the Department of Veterans Affairs (VA) Capital Assets Realignment for Enhanced Services (CARES) **PROCESS**

however, this is not "high implementation priority at this time". CARES is supposed to enhance services to veterans, however, this does not seem to be the case here.

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IN TENNESSEE

Further, outpatient primary care, outpatient mental health and outpatient specialty care demand is expected to increase in VISN 9. We have been told that this increase will be accounted for with additional capacity; however, we have yet to review any proposals or even know what facilities will be involved. VISN 9 also indicated that community contracts will be used yet do we really know that the community can absorb and provide these services to veterans? We cannot make informed comments without first seeing the VISN 9 ~~plan~~ detailed plan.

As for inpatient medicine we back the plan as it relates to increasing inpatient medicine services in the Central and Western markets to meet demand through a mix of in-house expansions (Nashville and Memphis) and community contracts (Chattanooga in the Central market and in outlying areas as available in the Western market) and expanding the Spinal Cord Injury Unit in Memphis by 20 beds.

One area that we are in total disagreement with is the concept of limiting or centralizing inpatient psychiatric care to one site within the Northern market. We do not concur with this proposal. Inpatient mental health patients in Tennessee should be able to receive this care in Murfreesboro and not in the State of Kentucky as is proposed. We note that this proposal does not meet the access driving time guidelines for inpatient mental health care established by VA.

Finally, we support the expansion of the National Cemetery located at Mountain Home. With 1,800 WWII and Korean era veterans passing on each day, this expansion, sadly, is needed.

Once again, thank you for this opportunity. This concludes my statement.

Statement of Don Samuels
Assistant Commissioner
Tennessee Department of Veterans Affairs
For John A. Keys, Commissioner
Tennessee Department of Veterans Affairs
Before the Capital Assets Realignment for Enhanced Services Commission
September 10, 2003

Mr. Chairman and Member of the Commission:

I am proud to represent Tennessee's over 550 thousand veterans. The Tennessee Department of Veterans Affairs has served in an advocacy roll for 52 years to build better lives for our veterans and their dependents.

Preservation of the integrity of the Department of Veterans Affairs (VA) health care system is of the utmost importance to Tennessee's veterans, and our nations veterans.

The veterans' health care delivery system was designed when inpatient care was the primary focus, long inpatient stays were common and access was open to any veteran in need of care. As demand for services increased, budgetary constraints forced Congress and VA to take steps to restrict access to health care with the enactment of complex rules and regulations to limit both care and services.

Throughout the 1990s to the present, efforts have been made in the public and private sectors to control the cost of health care delivery through efficiencies and cost cutting. VA has changed from a hospital-based health care system into an integrated health care delivery network. In 1996, landmark legislation opened enrollment to all veterans within existing appropriations.

In 1999, a Government Accounting Office (GAO) report found that VA spent approximately \$1 million a day on unused and underutilized space. GAO recommended, and VA agreed, that these funds could be better spent on improving the delivery of services and treating more veterans at more locations. In response to the GAO report, VA developed a process to provide the right care, at the right place, in the right setting.

The Capital Asset Realignment for Enhanced Services (CARES) was initiated in October 2000. The pilot program was completed in Veterans integrated Services Network (VISN) 12 in June 2001 with the Secretary announcing the final decision in February 2002. The remaining 20 VISNs were to be assessed in Phase II that began in June 2002.

Funding – Clearly, billions of dollars in discretionary appropriations will be needed to accomplish the new construction and approved renovations. CARES is an ongoing process, and incremental changes are anticipated. With the proposed consolidations and transferring of services, it is imperative that no veteran experience any delays in access to the delivery of quality health care, and patient safety must not diminish. No VA medical facilities should be closed, sold, transferred or downsized until the proposed movement of services is complete and veterans are being treated in the new locations.

Veteran's Population – There is some concern that the projected veterans' population is underestimated. Indeed, it might be underestimated based on the war on terrorism. Certainly with regard to long-term care, mental health, domiciliary and other specialized care populations, the CARES process has yet to incorporate projections.

Long-Term Care – VA spent close to \$3.3 billion on long-term care in fiscal year (FY) 2002. With the enactment of the Millennium Health Care Act, demand will most likely increase due to the aging of the veteran population over the next decade. VA estimates that the number of veterans most in need of long-term care, those veterans 85 and older, will more than double to about 1.3 million in 2012. Yet, even with these numbers, veterans long-term care needs and projected growing demand are not included in Phase II of the CARE process.

Mental Health – Due to several factors concerning the initial projections, the National CARES Planning Office (NCPO) and several other experts are reviewing the mental health inpatient and outpatient projections. Because of the questionable decline of demand in several markets, networks were instructed to plan for increase in mental-health services only. Stakeholders were very concerned about the mental- health projections and expressed dissatisfaction with the model.

Unutilized Space – According to VA's office of Facilities Management (OFM), VA facility assets include 5,300 buildings; 150 million square feet of owned and leased space; 23,000 acres of land; and a total replacement value estimated at 38.3 billion. OFM assessed and graded 3,150 buildings for a total of 135 million square feet with correction costs estimated at \$4.5 Billion.

More development is needed by the VISNs to more effectively utilize this unused space instead of just selling or demolishing these buildings. Once the buildings are gone, there will be no way of getting them back. Before any unutilized space is sold, transferred, destroyed or otherwise disposed of, the CARES process must consider alternative uses of that space to include: services for homeless veterans, long-term care and the expansion of existing services.

Contracting Care – Throughout the VA health-care system, contracting out of care is prevalent. While contracting may be necessary in some circumstances, the wholesale use of this health care delivery tool should be used with caution. Contracting out of care was extensive in the VISN proposals. Some VISNs made the blanket statement that care would be contracted out to meet excess demand in 2012 and 2022. Considering the extensive research and cost analysis that will have to be done concerning available resources (if they are available) within each community, TN Dept of Veterans Affairs does not believe that is much of a plan.

Enhanced use Lease Agreement – Through the use of EU leases, VA can receive cash or “in-kind” consideration (such as facilities, services, goods or equipment). Several of the VISN’s proposed enhanced-use lease agreements with the public and private sectors. VA should continue to seek opportunities in the area of enhanced use leasing. It can certainly have a positive impact on service delivery to veterans and local communities.

VA/DoD Sharing – There are many opportunities for sharing between VA and the Department of Defense (DoD). Both VA and DoD benefit from these agreements, and every effort should be made by the VISNs to pursue this avenue in order to save money through cost avoidance, in particular pharmaceuticals, supplies and maintenance services.

VA spent nearly \$1.4 billion in Tennessee in 2002 to care for almost 550,000 veterans who live in the state. Last year, 130,051 people received health care in the State’s VA facilities and 78,551 Tennessee veterans and survivors collected disability compensation or pension payments. Nearly 7,800 veterans and their families received GI Bill payments for their education, 67,763 owned homes purchased through VA home loan guarantee and 1,711 were interred in Tennessee’s five national cemeteries.

In Tennessee, VA operates four medical centers in Memphis, Mountain Home, Murfreesboro and Nashville. VA facilities in Tennessee increased outpatient visits from 718,892 in 1995 to almost 1 million in fiscal year 2002. Inpatient admissions declined from 29,914 to 21,842 over the same period. Tennessee medical centers offer an array of services that include acute medical, surgical, psychiatric and nursing home care. Ambulatory care clinics are located within each medical center’s catchment areas.

Community-based outpatient clinics are operated at Chattanooga, Cookeville, Dover, Knoxville, Mountain City, Rogersville, Tullahoma and nine sites in southwest Virginia. Additionally, Tennessee VA medical centers are parent facilities to community-based outpatient clinics in Ft. Campbell, KY., Bowling Green, KY, Savannah, TN, Jonesboro, AK, and Smithville and Byhalia, MS. Additional clinics are on the drawing board to open over the next few years. A domiciliary is located at the Mountain Home facility and offers social and psychological rehabilitation and long-term health maintenance. A 60 bed Spinal Cord Injury Center is located on the campus of the VA Medical center in Memphis. This center serves as a referral site for veterans being treated for quadriplegic and paraplegic conditions. Nashville operates a transplant program, and a Geriatric Research, Education and Clinical center (GRECC) is shared by Murfreesboro and Nashville. Murfreesboro has one of VA’s seven consolidated mail outpatient pharmacy programs on its campus.

All of the medical centers have affiliations with medical schools, including the James H. Quillen College of Medicine in Johnson City, Vanderbilt University School of Medicine in Nashville, Meharry Medical College in Nashville and the University of Tennessee At Memphis. Each facility offers residency training in major medical and surgical specialties and subspecialties. Associated health training is offered in nursing, psychology, audiology and speech pathology, social work, dietetics, pharmacy and other health care fields.

The Tennessee medical centers provide a wide range of services for geriatric and extended care patients. The programs include in-house nursing home care (both short-

term transitional care and longer-term supportive care), community based nursing home care and rehabilitation services. These extended care services are an essential component of the continuum of care required to meet the changing, complex and comprehensive needs of American's older veterans.

The primary goal of geriatric and extended care services is to maximize the patient and family independence, while maintaining autonomy, dignity and family involvement in care. In 2002, more than 44,600 veterans who were age 65 and over were treated by VA facilities in Tennessee. Additionally, Tennessee hosts one of only 20 VA geriatric Research, Education and Clinical Centers (GRECC), which focus on preventive health care and medication use for the elderly.

Tennessee medical centers have nearly 200 principal investigators working on more than 520 research projects. Current areas of research include pathogenesis of arthritis and other autoimmune disorders, diabetes, multiple sclerosis, gastroenterology, hypertension, schizophrenia, urinary incontinence, cardiology, nephrology, oncology, neurology, psychiatry, biochemistry, toxicology, pulmonology, hematology, endocrinology, wound healing, bipolar disorder, spinal cord injury, audiology, prostate cancer and many others. Many of the researchers work with their affiliated medical schools in joint projects.

Tennessee homeless programs are located at all VA medical centers and provides varying degrees of service. Each facility provides outreach that includes physical and psychiatric health exams, treatments, referrals and ongoing case management. Each medical center provides emergency and transitional beds for homeless veterans through community, state, and local organizations.

The Mountain Home medical center has an inpatient homeless program providing evaluation and treatment while veterans are in a residential setting and also a homeless outreach program with offices in Johnson City and Knoxville.

The Nashville medical center developed a transitional living residence for women in conjunction with Operation Stand Down Nashville, inc., to assist them in transitioning back into the community as productive citizens. Facilities are also active with local homeless shelters and community action groups that work together to provide services for homeless clients.

Additional Initiatives:

During 2003, the Nashville VA Transplant Program will celebrate 40 years of performing kidney transplants.

In June 2001, Energy Systems Group (ESG) opened the Mountain Home Energy Center, VA's first privately financed and operated energy development operation – and the first in the federal government using this type of public-private development authority and financing structure. This state-of-the-art energy facility will serve the energy needs of the Mountain Home medical center and East Tennessee State University's college of Medicine.

The initiative is expected to save VA more than \$28.5 million, with no capital outlay for VA. VA will also receive a percentage of the revenues from energy sales to non-VA customers. And plans to use the savings to support improved access to medical center based primary care and community-based outpatient clinics. The plant also has dual back-up power systems, which can provide 100 percent of the medical center's power needs in an emergency. This equates to low risk, cost savings, cost avoidance and more reliable delivery of health care to veterans.

A project to improve earthquake resistance of the original 14 story building at the VA Medical Center in Memphis, TN, was begun in 1996. This multi-phase project was designed to correct seismic deficiencies by removing the top nine floors of the original bed tower and replacing it with a new, six-story structure.

In phase I, a new addition was built that contains medical and surgical beds as well as clinical support functions. In Phase II, the upper nine floors of the existing medical center building will be dismantled. In the third and final phase of the project, the remaining five floors will be seismically reinforced. The project is slated for completion in 2005.

VISN 9

Tennessee

Veteran Population: 554,387 Enrollees: 121,323
Market Share: 22%

Memphis:

*Add 20 spinal Cord injury long-term care beds in the existing Memphis Unit

Nashville & Murfreesboro:

*Consolidate acute medicine at Nashville and retain a minimum number of medicine beds at Murfreesboro

Other Tennessee Proposals:

- Expand in-house and contract care for inpatient and selected specialty care in the Chattanooga and Knoxville Areas.
- Increase use of telemedicine to support specialty care needs.
- Expand existing outpatient clinics to include mental health.
- Increase the use of community contract services.
- Expand National cemetery capacity at Mountain Home.

Mr. Chairman, Tennessee Department of Veterans Affairs remains hopeful that the VA will do its utmost to meet its responsibilities to care for those who defended our nation. To do that, the US Department of Veterans Affairs has to remain mindful of its promise of "enhanced services" to carry out all of its missions. I strongly urge this commission to listen to all the concerns of Tennessee's Veteran service organizations and their National Organizations.

**STATEMENT OF
KEVIN D. NOEL
OF THE
DISABLED AMERICAN VETERANS
BEFORE THE
CAPITAL ASSETS REALIGNMENT FOR ENHANCED SERVICES
COMMISSION
NASHVILLE, TENNESSEE
SEPTEMBER 10, 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 this area in VISN 9.

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 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 provider of health 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 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. We are pleased with the opening of the new clinic recently opened in the Memphis area. We are certain that this will immediately benefit the veterans in the area. As service officers that are disabled veterans ourselves, we are in the unique position to field complaints and receive compliments about the services provided through both the VA Medical Centers (VAMCs) and the outpatient clinics. We are also active consumers of the services provided by the VA.

As part of our volunteer transportation network, we maintain six Hospital Service Coordinators in the various medical facilities. These coordinators help with claims submittals and organizing the transportation of veterans to and from their scheduled appointments. As such, we have a good feel for how the veterans of this region feel they are being treated.

A common complaint that we hear is that it takes an unreasonably long time to be assigned and be seen by a primary care provider. Even given the emphasis on expediting appointments for service-connected veterans the system does not have sufficient resources to provide quality care to the veterans in the system. Because of the long wait for care, veterans that are eligible to receive care through the VAMCs have instead elected to utilize private medical treatment. Certainly, this is negatively effecting the enrollment in the VA system and the current funding based upon usage. Consequently, it is clear that projected usage will decrease and future funding will be jeopardized for a medical system that can ill afford the cut to their budget.

The state of Tennessee has a population of over 550,000 veterans as of the most recent tally. We also have two major military bases and a large number of activated National Guard and Reserve units whose members will be immediately eligible for Veterans Administration health care benefits upon their return from the Middle East. The well-publicized incidents of mental stress due to the trauma of the current hostilities are made clear by the number of suicides reported. In the near future, there will be a large number of veterans, recently processed out of the military, who will be flooding the VA medical system. At this time, it does not appear that the current system can support the additional demand.

As mental health care is such an immediate and pressing concern, we are concerned about how quality care can continue to be provided to the veterans in the region of the VISN. Alvin C. York VAMC in Murfreesboro, Tennessee is the location where most inpatient mental health care is provided. Given the traffic and driving distances, this facility does not meet the driving distance or the time driving standard the VA must hold itself to. Opening clinics with non-VA psychiatric personnel may appear to solve the problem of accessible care on paper. As we have learned, having a veteran treated for mental trauma due to military service requires specialized training and understanding of the peculiarities of military service. Civil war veterans would indicate that anyone who had not seen the elephant (seen combat) would not believe you even if you took the time to explain fully to them what you had seen and experienced. A veteran describing his military experiences to someone without adequate background has been described as describing when and where the veteran had "seen the elephant." It is clear from reading medical examinations, that there is a great need for training of the treating and examining

physicians. Without this training, there is little chance of quality medical treatment or subsequent effective rating decisions.

We recognize that there may be facilities in the VA system that are a drain on the available resources. The outpatient clinic in Knoxville, Tennessee was closed and temporarily relocated due to black mold rendering the facility unhealthy. This solution allowed the VA to continue to provide medical care to the veterans of the area. The VAMC in Memphis, Tennessee is currently undergoing construction and improvement as it was found to have been located on an earthquake fault. The Nashville, Tennessee VAMC was recently studied to see if a co-located or integrated VA Regional Office would be feasible.

The Nashville VAMC site is attached to the Vanderbilt University Medical Center and enjoys access to the fine medical professionals working for that school. However, the site is landlocked with no possibility for expansion or integration. An argument for the expansion of the facility can be seen on Saturdays when the clinics are flooded with the veterans reporting for the “cattle call” compensation and pension examinations. There are upwards of fifty people in the waiting room, all waiting for an examination detailed enough to allow a rating decision to be made. We have received complaints of cookie cutter examinations where the veteran was rushed in, seen briefly, and rushed out. This kind of treatment has resulted in many veterans feeling that the system is not interested in or currently capable of providing quality care.

It is clear that the available space in the VA inventory might be used more effectively. Possibly space could be set aside for the special needs of the acutely disabled veteran population that will be making use of the VA health care system. With Vietnam veterans suffering from a number of systemic conditions, it appears that more treatment facilities could be adapted to suit the particular needs of the veterans rather than the VA divesting themselves of such valuable, and potentially useful buildings.

While contracting is touted as a viable plan for providing necessary services, we would question why these services would need to be subcontracted when there is currently an existing government agency with the infrastructure available to provide these services. It could be argued that the properties listed as excess would actually be ripe to modify to suit the needs of the veterans. The cost and time required to study proposed contracted care that could conform to the peculiarities of the VA system would undoubtedly be better spent trying to facilitate internal changes to support the needs of the veterans. Availability of quality care is subject to funding. Funding is subject to the number of enrollees in the medical system. The number of enrollees in the system is in direct correlation to the perceived quality of care provided.

Given the current political situation, and the fact that our active duty military service members are currently deployed in harm's way, it is clear that the system is inadequate. It is further clear that additional study and feedback from current consumers of VA medical care is necessary. To this point, we have been observers only in the CARES process. We stand ready to provide whatever assistance we can.

In closing, the local DAV members of VISN 9 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 veterans and their families. Thank you for the opportunity to present our views on these important proposals.