

**U.S. Department of Veterans Affairs
Capital Asset Realignment for Enhanced Services (CARES) Commission**

Full Commission Meeting

October 7, 2003

Washington, D.C.

Review of Draft National Plan

Commissioners in Attendance:

The Honorable Everett Alvarez, Jr., Chairman
Charles Battaglia
Joseph E. Binard, MD
Raymond Boland
Chad Colley
Vernice Ferguson, RNB, M.A.
John Kendall, MD, Vice Chairman
Richard McCormick, PhD
Layton McCurdy, MD
Richard Pell, Jr.
Robert A. Ray
Sister Patricia Vandenberg, CSC
The Honorable Raymond John Vogel
The Honorable Jo Ann Webb, RN
Michael K. Wyrick, Major General, USAF (Ret.)
Al Zamberlan

Chairman Everett Alvarez, Jr. called the meeting of the Commission to order at 8:30 AM in room 418 of the Russell Senate Office Building. He thanked Senator Arlen Specter, Chairman of the Senate Veterans Affairs Committee, for allowing the Commission to use the room. Chairman Alvarez said the Commission had conducted 60 site visits and 35 hearings in three months. Two hearings had to be postponed and are being rescheduled. He also said the Commission had received 27,000 comments on the Draft National CARES Plan (a figure he updated to 30,000 later in the day). Chairman Alvarez then introduced the first stakeholder.

**Statement of The Honorable David S.C. Chu
Under Secretary of Defense
For Personnel and Readiness**

Dr. Chu presented the perspectives of the Department of Defense on the CARES process and the Draft National CARES Plan. He said DoD and VA have launched a new era of collaboration over the past few years, establishing a relationship that is a model for interagency cooperation across the federal government. The VA-DoD Joint Executive Council, which he co-chairs with the Deputy Secretary of VA, provides senior leadership and oversight of a number of health care and personnel initiatives, including development of a Joint Strategic Plan. Coordination of capital asset planning and management is a major focus of that plan.

Dr. Chu said both Departments share the need for a critical self-examination of their systems, particularly with regard to alignment of infrastructure. CARES is an extraordinary effort to build the capability to understand the needs and priorities of a large, complex health care system. DoD enthusiastically supports the CARES approach; its methodology is an important tool for future planning and the identification of collaboration opportunities.

DoD has been a full participant in the CARES process. Representatives from the TRICARE Management Activity and from each of the three Services have worked closely with the CARES program office and VISN representatives. They actively participated in last November's nationwide CARES planning session to help develop the planning initiatives. As a result, over 60 sites were identified as locations for collaborative opportunities. Since then, DoD and Service representatives have maintained a continuing dialog with local facilities, regional offices and headquarters in both departments.

Positive outcomes of the collaboration include designating 20 of the 60 facilities as "high priority." DoD is now working on several projects in near-term planning, design or construction. CARES has allowed DoD to facilitate solutions at these locations. Examples cited includes a replacement community-based outpatient clinic (CBOC) in the Army hospital under construction at Ft. Wainwright in Alaska and design of a CBOC for the replacement hospital at Ft. Belvoir, Virginia. Additionally, the Air Force is coordinating enhancement of surgical services for VA beneficiaries in conjunction with an upgrade to the hospital at Langley Air Force Base in Virginia. Planning is underway for a joint clinic near the Navy hospital in Pensacola, Florida and a VA ambulatory clinic adjacent to the hospital at Elmendorf Air Force Base in Alaska. The Biloxi VA and the Medical Center at Keesler Air Force Base are discussing the consolidation of inpatient services. Navy is working with VA to incorporate a CBOC in the new hospital planned for Guam. In Denver, DoD and VA are working with the University of Colorado on a new patient care and research campus on the site of the former Fitzsimmons Army Medical Center.

Dr. Chu said DoD does have deep concern about the CARES recommendation to discontinue the partnership at the Michael O'Callaghan Federal Hospital at Nellis Air Force Base in Las Vegas, Nevada. He said the consequences of losing one of the most prominent and successful collaboration sites could be severe. The President's Management Agenda calls for increased DoD/VA collaboration in order to make the best use of federal resources. To many people, the proposal would represent a setback.

DoD is also concerned about the possible effect on its beneficiaries. The Air Force would lose the critical mass necessary to maintain inpatient services, adversely affecting support services to Nellis Air Force Base. While DoD recognizes that the veteran population of the Las Vegas area is growing, the model of collaboration successfully employed at Nellis can and should be reshaped to meet the evolving demand.

Dr. Chu said neither beneficiaries nor taxpayers would be appropriately served by implementing the CARES recommendation. Other alternatives should be explored to ensure the two departments optimize federal health care resources in the Las Vegas area. DoD is committed to working with the VA to explore all alternatives and develop a mutually advantageous solution that builds on the history of successful collaboration in Las Vegas.

Dr. Chu suggested that the recently-established VA/DoD Capital Asset Planning Committee (CAPC) might be the ideal venue to develop a solution. CARES has helped illustrate the

challenges the two systems face in executing and coordinating capital initiatives. The CAPC's charter is to further the recommendations of the President's Task Force by improving the business of VA and DoD capital investment. Its goals are to achieve an integrated approach to capital coordination, provide oversight to ensure collaborative opportunities for joint capital asset planning are maximized, and establish a strategic approach to facilitate and expedite mutually beneficial capital investments. DoD plans to use the CAPC in an oversight role to coordinate CARES initiatives, including reviewing alternatives that are available in Las Vegas. DoD will also use the CAPC to address DoD initiatives resulting from the future Base Realignment and Closure study.

DoD believes the CARES process is a significant milestone in furthering collaboration between the two systems. The outcome of the CARES effort has already identified real results that both agencies are committed to pursue, both through the early successes already demonstrated and through enhancements to processes and management oversight.

Q&A/Discussion

A Commissioner said the Commissioners' visits to Las Vegas had highlighted several issues. One is that security at the Air Force base limits veterans' access. Another is that the Air Force plans to use the entire hospital on the base – there are 5,000 more military personnel coming to Nellis. He understands that the Air Force is planning to build a new wing on the hospital and those involved are not happy with VA's position that it needs its own hospital in Las Vegas. He said his view is that Nellis is a large base and should have room somewhere for a VA facility. However, VA is concerned that its patients would get second-class treatment since the Air Force would be in control of the hospital. Another Commissioner added that there seem to be different philosophies of health care at work in the two systems.

Dr. Chu replied that the facility is working well. He agreed that there are some different work rules. But he believes it would be a mistake from an economic standpoint to establish two separate facilities. One larger facility would be far more economical to operate.

Another Commissioner, referring to Dr. Chu's reference to "a new era of collaboration," said that this is not evident at the local level. His experience has been that cooperation occurs only at the initiative of local VA and DoD officials. There is a lack of top-level direction and no formal guidance is provided to local military commanders. Agreements often don't survive a change of command. Some local units are not at all responsive to VA requests. He believes there are great opportunities but they are not being pursued by DoD.

Dr. Chu said he hears the Commissioner's message. At the same time, he said people have to be realistic about expectations. The desired changes won't happen quickly. DoD is focusing on selected markets – such as the I-45 corridor in Denver – in which to actively work on collaboration. In this case, DoD is working with the University of Colorado to establish a medical research facility at the former Army hospital, and it wants VA to come in on it, too. He said North Chicago is another example of an area that DoD has targeted. He also said budgetary limitations and other restrictions can interfere with smooth implementation. DoD has issued a series of memos and joint planning is occurring. He said he is disappointed to learn about the lack of local cooperation.

One Commissioner said her impression was that it was VA that was falling down, not DoD. Another said that the agreements that do exist are very complicated, requiring an enormous amount of effort on the part of base commanders to work out details. His opinion is there needs to be a direct and compelling order to go forward or people will get bogged down in the details.

Dr. Chu agreed with this position, saying he would prefer local units *not* cut their own deals.

A Commissioner agreed, said his experience has been that any agreement at the local level lasts only as long as the Commanding Officer stays there. Another Commissioner endorsed the need for more top-level guidance and direction. She also said she hopes VA will respond to DoD in a timely way, especially in the Denver area. A third commissioner commented that the military command structure is more complicated than VA's, which may be part of the problem.

A Commissioner asked Dr. Chu to comment on the relationship between capital assets and the quality of care, noting that it seems like VA's quality has improved as its infrastructure has deteriorated while the opposite has been the case in DoD. Dr. Chu said DoD is trying to improve its posture in that regard. He also said the people who have hardest time getting service – retired military personnel – are the least critical of the system, whereas younger, active military personnel are more critical.

Stakeholder Panel - VSOs

**William Bradshaw, Director of the National Veterans Service
Veterans of Foreign Wars of the United States**

**Cathy C. Wiblemo, Deputy Director for Health Care
The American Legion**

Mr. Bradshaw began by telling the Commission that VFW is ready to work with VA to help focus resources where needed. VFW supported CARES because the alternative would have been something similar to a BRAC – base reduction and closing. He said VFW units across the country have been providing input to CARES on a case-by-case basis.

The VFW is frustrated with the CARES process and with the lack of details in the Draft National Plan. He cited the recommendations for Biloxi as an example. The plan proposes to transfer patients from Gulfport to Biloxi, but there isn't enough space at Biloxi for the workload they have now. The plan is silent on how the proposed transfer would be accommodated. Mr. Bradshaw said this is only one of several examples he could cite. At the same time, he said the VFW recognizes that some VA real estate is old and not useful.

Ms. Wiblemo said the Commission has heard about the concerns of the American Legion at its local hearings and said the Legion has also submitted a formal statement. The Legion's major concern is the absence in the plan of long-term care, mental health and domiciliary care recommendations.

She said the local units of the Legion have been critical of the Commission's process at local level and the lack of opportunity for participation. One concern is that the witnesses at the local hearings weren't given enough time – three minutes instead of the customary five. The Legion is also concerned that the Under Secretary for Health didn't take stakeholder comments into

account when preparing the Draft National Plan. The organization is also concerned that the Draft National Plan does not reflect the local initiatives that were submitted to VA.

Another concern is contracting out health care. The Legion believes that VA should be a *provider* of health care for veterans, not a *purchaser* of health care.

Ms. Wiblemo noted that the Draft National Plan includes a large number of projects and that substantial funding will be required. Her organization is concerned that the projects might be under-funded.

Q&A/Discussion

A Commissioner explained that the problem with the time allowed for witnesses at the local hearings stemmed from the fact that local representatives began their statements by setting out the position of the national organization. They could have omitted that from their statements and would have had more time.

Another Commissioner asked for additional details regarding the reasons for the concerns with contracts. Ms. Wiblemo replied that contracting out health care “raises a red flag.” The Legion likes the VA system. It has questions about how contracting out will work.

A Commissioner asked for comments on how the Commission should reconcile concerns such as Biloxi with concerns about older facilities. Ms. Wiblemo said the Legion understands that the CARES process won’t end with the Secretary’s decisions. After that, proposals will be in the strategic plan. The organization’s biggest concern is what will happen when implementation starts. There is concern that changes will be made in the plan over the years. Care should be taken that the veterans’ health care system is not lost.

Another Commissioner observed that the changes won’t be accomplished without some degree of difficulty being imposed on some veterans. He asked whether the Legion is committed to moving forward even under these conditions. Ms. Wiblemo answered that the Legion is committed to going forward.

One Commissioner asked if the VSOs had any information from VA to suggest that they would be involved in the planning for other aspects of care – mental health, long-term care and domiciliary care —when that happens. He asked about their level of confidence regarding their future involvement. Both VSO representatives replied that they hadn’t been told anything yet. However, they are assuming they will be involved.

A Commissioner observed that the process so far has been data driven with the Networks having to fill in the gaps. He said it looks like this may be providing the justification for some ill-defined solutions. The question is who owns the process. He said the Commission is aware that the Secretary needs specificity.

A second Commissioner observed that contracting out was the number one issue everywhere he went. The Commission understands the concerns – veterans have conditions that civilian doctors just don’t know about. Even so, his experience has been that contracts are used only where necessary and they are written to ensure appropriate consideration of veterans’ needs.

Ms. Wiblemo responded by noting that rural health care is a particular problem. The Legion's position is that contracting out health care has to be looked at very seriously and has to be treated cautiously. It must not compromise what the VA is known for. Mr. Bradshaw said VFW looked at the VISN plans very carefully and agreed with many of the contracting recommendations.

Stakeholder Panel-VSOs

**Rebecca Vinduska, Director of Governmental Relations
Blinded Veterans Association**

**James King, National Executive Director
AMVETS**

Ms. Vinduska began by noting that the Blinded Veterans Association is the only organization dedicated to the needs of blinded veterans and their families. However, the organization is also concerned with larger issues. The Blinded Veterans organization supports the CARES concept, but it is concerned about the aggressive time line. It is also still concerned about some of the items that are not included in the Plan, although it is glad VA had data on blind veterans.

The new Centers proposed in the Plan definitely will help those blinded veterans who are waiting for treatment. Her organization is also concerned, however, about the veterans who can't get to the Blind Rehab Centers. VHA still needs to provide space for them in other facilities and provide for them to receive care at CBOCs. The Blinded Veterans Association is also concerned that the Under Secretary for Health did not take the VISN's recommendations for blind rehabilitation where the VISNs included them. It is also concerned about the changes in the market plans when the Draft National Plan was issued. Where the VA is closing facilities, her organization wants assurances that blind patients will be moved to suitable, special facilities. Ms. Vinduska closed by saying that the Blinded Veterans Association will work to make sure blind veterans will have access to the services they need.

Mr. King said his organization has supported veterans since 1944. The organization has submitted a statement for the record. Its comments concern the foundation of the Draft National CARES Plan document, which are summed up in the bullet points on the opening page. The AMVETS view is that points four, seven and eight do not appear to have been totally complied with by VA.

Point Four concerns "exploration of alternative use of campuses to benefit veterans, such as assisted living facilities or other compatible uses, with revenues used to invest in veterans services." AMVETS notes this is an excellent concept but is disappointed that the Plan does not contain any detail as to what the "other compatible uses" are or how they would be implemented.

Point seven involves "a description of internal collaborations between the three VA administrations and external collaborations with the Department of Defense (DoD) to maximize joint utilization of capital resources." AMVETS agrees that the internal VA collaborations appear to be sound and promising but does not believe the collaborations between VHA and DoD are. The appearance is that many VISN Directors and base commanders are only seeking what is in their own best interests, not what is in the best interests of veterans or service members.

Point eight deals with “A description of stakeholder involvement in the process.” AMVETS is concerned that too many VISN Directors seem to have forgotten that the primary priority within the stakeholder community is the veteran, followed by the employees, then by other interested parties. Moreover, some Directors seem unable to differentiate between a veteran and a veteran service organization (VSO).

Mr. King said his statement provides additional details on each of these points.

A concern of AMVETS is that the Plan includes numerous instances where contracting out health care is recommended even though VA care is consistently higher quality. Another concern is that there are 270,000 homeless veterans and domiciliary units are being closed or relocated. He cited the Bedford, Massachusetts, proposal as an example, noting that moving the facility to a location (Northampton) where it would be inaccessible to homeless veterans in the Boston area would affect almost one-third of the domiciliary care beds in the VISN. Mr. King said there are 7,000 homeless veterans in Massachusetts, 2,500 of which are in Boston. AMVETS concerns is that many VHA facilities could be rehabilitated to house homeless veterans. Instead, the Plan proposes to close them.

AMVETS does agree with the need to upgrade and replace outdated facilities. It recognizes that doing this will take money. The AMVETS position is that Congress should provide VHA with mandatory funding to allow VA to maintain an adequate long-term capital program.

Q&A/Discussion

A Commissioner said the Commission had heard during the hearings about the patients’ satisfaction with VA outpatient services. However, the Commission is charged with looking at capital assets, not at programs and services. In regard to blind rehabilitation, she said the organization should weigh in on the question of where the facilities should be located.

A Commissioner asked for the panelists’ views on evening and weekend hours for medical services. Mr. King said he is a beneficiary of the extended hours and likes them very much.

Another Commissioner asked about the VISN’s recommendations regarding the Blind Rehab Center in California and where it should be located. Ms. Vinduska said her organization does not have a “party line” on this matter. Where to locate facilities is a local decision. The concern of the national organization is capacity.

One Commissioner expressed disappointment that the VSO wouldn’t support any reductions, closings or contracting out. He asked whether they could support anything along these lines. Otherwise, he is not sure how VHA is supposed to distribute services. Mr. King said AMVETS would support contracting out in specific cases where other options are not practical, such as in rural areas. However, it does not want large-scale contracting out. The problem is with contracting for the provision of outpatient care. He said it will be difficult to find physicians who will agree to accept payments at the levels provided by VA.

A Commissioner said the Commission had received more conflicting testimony from blind veterans than from any other group. In fact, he said they had testimony in Waco that took both sides. He suggested that the National could be helpful by being more specific. He also

cautioned that the fact that a building exists does not mean that money will be made available to rehabilitate and maintain it.

Stakeholder Panel-VSOs

**Michael Tomsey, National Service Director
Military Order of the Purple Heart of the U.S.A., Inc.**

**John Bollinger, Deputy Executive Director
Paralyzed Veterans of America**

Mr. Tomsey noted that for Purple Heart, the only Congressionally-chartered veterans organization with membership exclusive to combat wounded, medical care is a primary concern. Its membership's views on CARES are varied. Some oppose closure or change of services provided by any facility; others agree with the tentative plans. All agree that improved quality and care of service is necessary and appears evident in the efforts of the CARES Commission.

The organization sees CARES as a good thing if timeliness and quality of service is increased based on the demographics of the veteran population and not on political strength. It also understands that buildings going back 50 years or more may be better utilized for different service. There is a real need for more Community Based Outpatient Clinics as demonstrated by their high usage and quality of care. Knowing the needs of many veterans, such as the 18,000 veterans on the Navajo Reservation, this program should provide them with a medical facility or clinic within their travel limitations. This group of veterans could be one of the important measuring sticks as to the effectiveness of CARES when implemented and they are a good measurement of the overall process of providing medical care.

The VA health care system is about providing services to as many veterans as possible without posing any limits to that care. Accordingly, the closure of some hospitals to provide other medical services appears appropriate. The facilities can be used as CBOCs, veterans' nursing homes and day-care treatment facilities. The primary concern when making the changes is that all veterans in the service area have cost-effective quality medical treatment, including inpatient surgical treatment. This should and must include contract emergency medical service with local hospitals at no cost beyond what would have been incurred by the veteran at a full-service VA hospital.

The proposal to reallocate funds to provide services to more veterans is commendable. Purple Heart sees CARES as an opportunity to increase, not downsize, medical staff and services for veterans. It is essential veterans be cared for at the highest possible level. There are many new injured and combat-wounded veterans and the quality of medical care for veterans can affect decisions about whether to join the all-volunteer military. Mr. Tomsey cited the example of one Vietnam Veteran who asked his sons to visit a VA Medical Center, talk to veterans and observe their care before deciding whether to enlist. The result was his sons chose not to enlist in the military. He believes the outcome might have been different if the young men had spoken to veterans who felt better about the VA or visited a different VA facility.

The conclusion is that change is necessary to meet the demands for treatment of veterans based on their location and needs. Purple Heart would appreciate the opportunity for all veterans and VSOs to respond to recommended changes before they are implemented.

Mr. Bollinger informed the Commission that PVA has provided detailed written comments, given testimony to all VISNs and attended most of the hearings. PVA has a vested interest in the outcome of CARES. Its primary concern is the future of VA's spinal cord injury (SCI) treatment system. For PVA's nearly 21,000 members, there is no alternative health care delivery system that can provide the complex, specialized medical services needed. The ability of the VA system to meet the increasing demand for acute SCI and long-term SCI care is critical.

PVA believes the CARES process worked pretty well. It is pleased that the Draft National Plan provides for a much-needed expansion of VA's SCI Centers. The new Centers will enhance VA's ability to meet the growing demand for SCI care and reduce travel distances and waiting times for veterans. PVA's position is that all proposed new SCI Centers must have a minimum of 30 beds, for operational efficiency, and be located in a VA tertiary care hospital, to ensure access to the numerous VA medical specialties. SCI patients require a full range of VA diagnostic, surgical and therapeutic services, including neurologists, neurosurgeons and plastic surgeons.

In regard to long-term care, PVA believes that the Draft National Plan takes a positive step by adding new beds in Tampa, Memphis, Cleveland and Long Beach. However it is disappointed that the market plans with long-term care beds did not get accepted in the Plan and would like the Commission to look again at the need for expansion of the long-term care facility in VISN 1 – Brockton.

PVA is concerned about the lack of a timetable in the Draft National Plan and the need for VA to incorporate appropriate phase-in procedures during the implementation phase to ensure no disruption of veterans' access to care. Additionally, VA should ensure that referral protocols are properly implemented.

PVA also supports assisted living as a viable alternative to nursing home care for veterans but is concerned that many state regulations are "not friendly" to people with disabilities. It calls on VA to make sure that veterans with disabilities are eligible for admission before approving any VA enhanced use lease agreement.

Two specific PVA concerns cited by Mr. Bollinger are the proposed new SCI Center at North Little Rock and the Long Beach proposal to reallocate 30 existing acute care SCI beds to long-term care beds. PVA opposes the latter change and recommends looking at the Shreveport or the Florida panhandle as possible alternatives to the North Little Rock facility.

Q&A/Discussion

One Commissioner agreed with the PVA position that SCI Centers should be collocated with tertiary care facilities. He asked Mr. Bollinger about the proposed North Little Rock Center, which would not have that feature. Mr. Bollinger suggested VA should look again at its options and come up with the right answer.

Another Commissioner asked about the difference between regular long-term care beds and SCI long-term care beds. Mr. Bollinger answered that SCI beds need more acute care and a higher level of skilled nursing. He said it is important to preserve acute care beds and that SCI patients have different and special needs.

One Commissioner noted that Mr. Bollinger had cited the Florida panhandle as having a tertiary care facility that could serve as a location for a new SCI unit, but he doesn't know of any VA tertiary care facilities in that area.

A Commissioner said the Commission wants to be very aggressive about care for SCI patients. At the same time, he is hoping that PVA will be flexible about some things. He cited the organization's opposition to using SCI beds for other than SCI patients on occasion as an example. Mr. Bollinger replied that when VA starts using SCI beds for other reasons, it erodes the capacity argument that PVA has worked to build up over several years. He said there are waiting lists for SCI beds. The Commissioner asked PVA to provide data in regard to utilization, and Mr. Bollinger agreed to do so.

Another Commissioner asked about the difference between a "certified team" and an SCI Center. Mr. Bollinger said that a "certified" or "primary care team" has been given special training to deal with SCI patients outside of an SCI Center and is equipped to evaluate the patient's needs and provide the necessary and appropriate care.

A Commissioner asked whether PVA believes that having a few designated long-term spinal cord units is the right way to go. He also asked about PVA's interest in VA nursing home units and PVA's position on contract nursing homes. Mr. Bollinger replied that PVA opposes any effort to increase referrals to contract nursing homes. PVA believes that VA should respect the desire of veterans to continue to live in their community.

Stakeholder Panel – VSOs

**David Gorman, Executive Director
Disabled American Veterans**

**Gerard Kelly, Executive Director
Eastern Paralyzed Veterans of America**

**Rick Weidman, Director of Government Relations
Vietnam Veterans of America**

Mr. Gorman told the Commission DAV supports the CARES process. He said veterans from the Iraq war will need care for a long time to come – 25 or even 50 years from now.

His organization has a concern about whether the massive amount of data involved in CARES can be scrutinized, analyzed and organized in a timely manner. It is also concerned about the treatment of special groups – long-term care, mental health and domiciliary care – and the data available for them.

He said DAV is not concerned about contracting unless it becomes the “easy way” to take care of veterans. He emphasized, however, that contracting has to be done in a practical, meaningful, thoughtful way.

DAV is concerned that any money realized from the *sale* of VA facilities would be lost to the VA healthcare system. Under current law the money would go the Treasury. DAV believes that the money should come back into the system. Also, where buildings are to be removed, the change should not be effectuated until plans are in place to take care of the patients currently being served in those facilities.

Mr. Gorman observed that in the current budget environment with finite resources veterans are not a priority. DAV believes this is short sighted and recommends mandatory funding as the most beneficial approach to the problem.

Mr. Kelly began by noting that his organization, now over 57 years old, has closely monitored the CARES process and has been intricately involved with Phase II since its inception. EPVA agrees that infrastructure analysis is necessary but has a number of concerns, both nationally and at the network level. Consequently, EPVA believes the CARES process is flawed and the Draft National Plan must not be allowed to move forward without major modifications.

One major concern is the speed with which the CARES process has advanced. Instead of a multi-step process with individual VISNs being evaluated, all 20 VISNs were lumped together for simultaneous evaluation. This overly ambitious approach pressured the VISNs to adhere to an arbitrary timeline, which sacrificed quality for speed. EPVA expressed its concern to Secretary Principi. Even so, the time allotted to the Commission to evaluate the Plan is longer than the time allotted to the VISNs formulate it.

A greater concern is the veracity of the data on which the entire exercise was built. EPVA is especially concerned about several of the major assumptions. One is that CARES presupposed there would be no military conflicts during the twenty-year period covered by the Plan – a faulty assumption. No future planning process is foolproof, but assumptions must be grounded in reality. Had the same assumptions been used in the 1960’s, the Vietnam veterans would have come home to a VA system with little or no infrastructure. We must not place ourselves in a situation where we are completely unable to deal with what the future holds.

EPVA is also troubled by the fact that VA has completely excluded veterans in priority groups seven and eight from the twenty-year projected usage data. These veterans – who have no service-connected disabilities and incomes higher than \$24,000 – are the fastest growing segment of VA’s patient population and are flocking to VA in search of health care and low-cost prescription drugs. By law the Secretary must make a decision annually about VA’s ability to treat each category. Excluding category seven and eight veterans from CARES amounts to making the decision for the next twenty years and will create a system that does not have the infrastructure necessary to treat these veterans. If Congress agrees that priority seven and eight veterans should not have access to VA care, it should repeal the Eligibility Reform Act of 1996. Until such legislation is passed, VA must not be allowed to create a system that cannot treat those veterans.

Of further concern to EPVA is the treatment of special emphasis programs, particularly the spinal cord injury program. One example is the lack of inter-VISN collaboration. Each VISN

developed its own market plan without the collaboration of adjacent networks, so inter-VISN referral patterns are not effectively addressed. This is of special concern to the SCI program, which draws services from multiple Centers located in multiple networks.

EPVA is bothered by the fact that the SCI data was not released until two weeks before the original February deadline for submission of VISN market plans. Although VA extended the deadline, VSOs and the VISNs had to wait an additional time to get the data. VISNs moved ahead anyway and their market plans were already conceptualized before the data were received.

The treatment of SCI long-term care is also troubling. The CARES data identified a system-wide need for SCI long-term care beds, but only four VISNs proposed expansion of their dedicated SCI long-term care capacity. Also disconcerting to EPVA is the fact that, through CARES, VA is disbursing SCI-designated long-term care beds onto geriatric and extended care units rather than maintaining these beds in a separate and distinct setting, which is required by statute. VA cannot legally offer mandated SCI services in a non-SCI program. Moreover, a constant SCI patient concentration is necessary.

There is a major difference in the quality and range of services that can be provided in an SCI long-term care unit, as evidenced by the two specialized SCI extended care centers. These centers have mandated staffing levels and a concentrated patient population that allows for the expertise necessary to offer quality SCI care. From acute injury through the end of life, an SCI patient will always require specialized services. Consequently, EPVA opposes the disbursement of SCI long-term care beds onto the geriatric and extended care wards.

Another issue of concern is VA's apparent targeting of its mental health program. Twelve of the fourteen facilities slated for closure or discontinuation of inpatient services have a major psychiatric services component. This concerns EPVA because many of its members are "dual diagnosis" patients who suffer from a variety of mental illnesses in addition to spinal cord injury or disease. Especially appalling is the fact that VA has refused to run an official data set for its mental health program through the CARES process and has maintained that it would not be affected. Closing twelve mental health facilities will, in fact, impact this population. VA has always maintained that CARES would be a data-driven process. Excluding this population from the CARES data set and subsequently closing twelve mental health facilities invalidates the entire process.

A final issue noted by EPVA concerns the unrealistic expectation that Congress will adequately fund all of the changes proposed in the Draft National Plan. VA already struggles to obtain annual health care funding. EPVA is concerned that when the cost of CARES implementation is factored into the appropriations process, Congress will not fully fund both the health care system and CARES. The lack of a comprehensive cost estimate for the proposed changes compounds the issue. CARES calls for the consolidation of existing facilities, construction of new facilities, shifts in health care services and a host of other changes. EPVA believes such changes must not begin until sufficient funding is secured to carry it out to completion. Moreover, no consolidation should be permitted until the necessary infrastructure exists to allow for the absorption of the affected patient population without gaps in service.

Mr. Kelly concluded by saying a data-driven process must have impeccable data; CARES does not. A future planning process must have a realistic outlook on the future; CARES does not.

While CARES is well intentioned, the process is flawed on so many levels that its integrity is negated. EPVA believes the Draft National Plan is invalid and must not go forward.

Mr. Weidman began his statement by stating the Vietnam Veterans of America has endorsed the CARES concept and proper stewardship. He said the stewardship of the VA physical plant for past fifty years has been execrable. We must move forward. The current formula does not take into account a patient's military history. It is critically important to connect a veteran's military history to a medical database.

Funding for veterans health care is a major problem. There is a structural shortfall that results in veterans getting sixty cents on the dollar compared to what they were getting in the mid 1990s.

One VVA concern is that the data were skewed from the outset by being based on a civilian formula of three to four presentations a year per individual. The actual VA experience is seven presentations per individual per year. If CARES is based on the wrong assumptions, the resources will be inadequate from the start.

Mr. Weidman said funding for veterans' health care is a major problem. The funding base must be restored. He distributed a handout providing information and data on that subject. VVA believes that the way in which medical operations of the VA are funded must be restructured, preferably through assured funding of veterans' health care in addition to restoring base funding. While VA enrollee growth continues to grow annually and rapidly, per capita expenditures have decreased and critical patient care ratios (such as doctor/patient and nurse/patient ratios) have shot up.

VVA is concerned that the Draft National Plan recommends eliminating some mental health facilities. Furthermore, a lack of funding for mental health disciplines seems to be built into the formula itself. This will diminish care for the most vulnerable veterans. Moreover, the plan left out services that VA must maintain by law, such as mental health and long-term care. These are the core of the VA's mission. Mr. Weidman suggested the Commission focus on what should be the purpose of VA; CARES did not do this. VVA's view is that it must be a veterans' health care system.

Unfortunately, the CARES formula skews the distribution of services toward population centers – the urban/suburban environment and the middle class population at the expense of smaller areas. He cited Butler, Pennsylvania and Highland Park as examples.

VVA opposes VA's abdication of responsibility for overall health care management for veterans. It should provide for veterans health care of the highest possible nature. Closing facilities without knowing where their patients will go for care is irresponsible. Alternatives should already be developed and tested to accommodate patients before implementing any closures or consolidations.

Mr. Weidman closed by saying that VVA does not oppose contracting out where that makes sense.

Q&A/Discussion

The Chairman assured the panel that the Commission has also been very concerned about the plans for accommodating patients where facilities are proposed for closing or consolidation.

One Commissioner asked Mr. Kelly to comment on where VA should consider placing SCI facilities in New York to replace Castle Point. Mr. Kelly said Syracuse makes the most sense, but there would be an inter-VISN problem doing that. Veterans go wherever they can get their needs met best. The Commissioner also asked about Philadelphia as an alternative.

A Commissioner said the question of new CBOCs came up in the Commission's hearings. The Commission was told that many more are needed than are included in the plan. The Commission understands that staffing limitations are a problem. He asked the VSOs representatives about their views on the Draft National Plan lowering the priority of recommended new CBPCs. The DAV representative said what happened with the CBOC proposals is one example of the lack of VA operating funds. He said some of the 48 CBOCs targeted as high priority may already have been in the pipeline. He noted that staffing for CBOCs comes at the expense of other services. His view is that VA just needs more resources.

Another Commissioner said the Department of Defense went through a similar process in the 1990s with its medical services. He said he has been impressed with the CARES process. He is especially concerned about the comment that CARES didn't take into account possible future wars. Noting that this question was discussed extensively in VHA, he concluded that there is just no way to accurately predict what might happen. He asked the VSO stakeholders what formula they thought should be used to figure out how big the VA health care system should be.

Mr. Weidman answered by saying the way to account for future needs is to figure out where we are going. The real problem is that there is no wiggle at all left in the system now. The VSOs haven't been able to trust any VA assurances relating to this process going back to 1996. For example, the VSOs were assured that certain closures – such as Albany – would be replaced by CBOCs. It wasn't true. The VSOs were told that there would be a "temporary freeze" on the priority seven and eight veterans. It now goes through 2023. The VSO experience has been that once they allow VA any latitude at all, it takes ten country miles.

The Commissioner said he was looking for a single formula to use to tell the Secretary how big the VA health care system should be based on future conflicts.

A Commissioner asked the VSO representatives if they had any suggestions concerning what to do about the awkward situation involving money received from the sale of VA property. Mr. Gorman indicated the DAV is supporting legislation to fix the problem by allowing the money to come back into the VA system.

Another Commissioner asked Mr. Kelly to clarify what EPVA means by its recommendation that "it must not go forward." Mr. Kelly said EPVA means that the *Plan* should not go forward.

A Commissioner asked if the VSOs are familiar with the data call that went out from the Under Secretary and, if so, whether they believe it will provide for filling the gaps in long-term care. None of the VSO representatives were sufficiently familiar with the new data call to comment.

A Commissioner also asked if the representatives had any reaction to the fact that the Draft National Plan only calls for a vacant space reduction of 42 percent over 20 years. The VSO representatives said they would review that aspect of the plan and provide comments. Mr. Weidman commented VA could use this space to provide flexibility in the system during implementation.

Commenting on the concept of going forward based on the data at hand, one Commissioner said he believes the best basis for projecting future needs is “force structure.” The number of beds should grow as the force structure grows.

Another Commissioner observed that Mr. Kelly’s statement had excluded remarks on the proposal to establish critical access hospitals that were included in his written statement. He asked Mr. Kelly why he had left them out. Mr. Kelly said time limits were the reason. He explained that EPVA does not see how critical access hospitals fit with the model and that the proposals do not fit the definition of critical access hospitals.

The Commissioner also asked the VSO representatives if they had any data about how many veterans lock in to the VA health care system just for the low-cost drugs. Mr. Gorman said DAV does not believe it is a good idea to use the system just for drugs. The objective of the VA system should be quality health care.

Another Commissioner assured the VSO representatives that inter-VISN collaboration, which they had mentioned as a shortcoming of the CARES process, has been an area of concern for the Commission.

**Dialog With Dr. Robert Roswell
Under Secretary for Health
Department of Veterans Affairs**

Dr. Roswell complimented the Commission on the work it has been doing with the Draft National Plan. He used his time for questions and answers with no prepared statement.

Critical Access Hospitals (CAH)

A Commissioner noted that one question that had come up at every hearing concerned the *definition of a Critical Access Hospital (CAH)*. She asked Dr. Roswell to clarify the meaning of this term as it is being used for VHA planning. Dr. Roswell answered that VHA had plagiarized the term “critical access hospital” from CMS – the Medicare system – but stressed that the term doesn’t translate exactly. The VHA concept is that a CAH would provide for inpatient stabilization and evaluation, treatment of minor illnesses and perhaps minor surgery. Stays would be limited to no more than 96 hours and CAH facilities would not offer critical care. Dr. Roswell sees the concept as being especially applicable to rural areas, and cited Cheyenne, Wyoming as an example. The only option for VA patients in that area is to travel to Denver, Colorado, for treatment. This is a long trip which patients want to avoid for relatively minor procedures. Dr. Roswell also agreed that VHA needs to develop a policy for designating critical access hospitals, but said the organization doesn’t have enough wisdom to do that right now. He sees developing a definition as a “work in progress” – something that will evolve over time and with experience.

The Commissioner followed up by noting that VA, unlike Medicare, has proposed designating facilities as critical access hospitals even when there is a community hospital in the same area. She suggested that VHA might want to consider using some language other than “critical access hospital” for its designations. Dr. Roswell said he would consider this suggestion. He explained that VA might, indeed, have designated facilities in the same locales as community hospitals. However, he considers separate VA facilities to be necessary from two perspectives. One is the quality of care available to veterans. VA already has the staff and capability in place to provide care for veterans in these areas. The other is economics. Dr Roswell noted that VA often has to pay a premium of as much as 25 percent for veterans care at community hospitals.

New CBOC Designations; VHA Priorities

Another Commissioner commented that the Draft National Plan appears to distribute new CBOCs in a way that is upsetting people. He cited the proposal to establish new CBOCs in VISN 16 but not VISN 23 as an example. The Commissioner asked for clarification of the rationale behind the 7,000-enrollee criterion for establishing a new CBOC.

Dr. Roswell explained that his concept was to use CBOCs to address *access* gaps rather than *capacity* gaps. Establishing new CBOCs has a tendency to increase VA’s market penetration in the lower priority brackets (priorities seven and eight). This is not as economical or efficient for VA as establishing CBOCs to increase access to health care for all priority categories. Dr. Roswell emphasized that the Draft National Plan included all recommended CBOCs but did assign a higher priority to those that met the enrollment criterion.

A Commissioner commented that some rural areas with enrollment populations of 4,000 or 5,000 could make better use of CBOCs than some areas that met the criteria. Dr. Roswell agreed.

Long-Term Care and Mental Health Proposals

A Commissioner asked Dr. Roswell to explain the rationale for proposing selected interventions in long-term care and mental health while omitting them from consideration across the board.

Dr. Roswell answered that the long-term care and mental health proposals in the Draft National Plan had been included on *proximity* grounds to achieve operational efficiencies. In preparing the plan, VHA examined all two-division facilities for possible consolidation. This process did not target long-term care or mental health facilities but, as a practical matter, that’s what the VISNs proposed. It is both cheaper and better to move long-term care and mental health facilities to be collocated with the tertiary care facilities than to construct new tertiary care facilities at the site of the LTC and mental health facilities. Additionally, collocation enhances the quality of care by putting long-term care and mental health together with other services. As part of the process, VISNs were told not to reduce bed capacity. All long-term care and mental health proposals are for realignments. Dr. Roswell also said he believes that veterans deserve state-of-the-art long-term care, which can’t be made available by renovating older buildings. The preference was to identify new construction.

Stakeholder Input

A member commented that many of the stakeholders that testified before the Commission felt that the new plan -- that is the Draft National Plan issued by VHA in place of the market plans

submitted by the VISNs – had introduced a new variable and that there had been no opportunity for stakeholder input to this plan. She asked Dr. Roswell to comment.

Dr. Roswell said he didn't anticipate this reaction. However, he believes that stakeholders have had significant input to the Draft National Plan through their participation in the Commission's hearings.

Another Commissioner asked about VA's experience in VISN 12 and what was learned from the program in that Network. Dr. Roswell replied that VA learned a great deal from its VISN 12 experience, not the least of which was that this is not an easy process. VA has to be facile, malleable and receptive to stakeholder input. The key is communication, communication, communication. The process is not done when a decision is made. VA is making good progress in VISN 12. The patients from Lakeside have been relocated. In regard to the proposed new construction, Congress has provided VA with the authorization, although not an appropriation.

Implementation Planning

A Commissioner noted that many of the proposals in the Draft National Plan are linked – one proposed action either requires implementation of another proposal or affects another proposal somehow. He observed that the key to the success of these linked proposals is to offload some of the primary care workload. He asked Dr. Roswell if VA had issued any guidance or direction in these cases that the Commission can rely on in evaluating these proposals.

Dr. Roswell replied that VA will maintain outpatient capacity where closures or realignment are proposed. In these cases, VA won't consider the facility as a CBOC. He said offloading primary care capacity has been a difficult concept in practice. When VA has attempted to move primary care, the result has been to create additional demands for care that weren't anticipated. As a result of this experience, Dr. Roswell said he has concerns about moving primary care out of medical centers just to reduce capacity. He believes a better choice is to expand the primary care facility.

Another Commissioner again raised the issue of the definition of a critical access hospital. He said the Commission asked the Network Directors to tell the Commission what it ought to be. He asked Dr. Roswell whether small hospitals are off the table and whether VHA has tested first to determine the capacity in the community. Dr. Roswell replied that the South Dakota facility is probably the only true example of a critical access hospital. Most of the other places proposed for a CAH designation have community facilities close by. Dr. Roswell said his fundamental belief is that VA shouldn't rush to convert veterans health care to community-based care. Veterans deserve quality care, which means sending critical care patients to tertiary facilities where they can get the right care.

Enhanced Use Leasing

A Commissioner observed that the plan was very dependent on enhanced use leasing but said the Commission encountered many problems with the enhanced use lease process everywhere it went. She asked Dr. Roswell to comment on how VHA plans to address these problems. In reply, Dr. Roswell acknowledged that the enhanced use lease process is fraught with problems. VA has proposed legislation to eliminate some of the problems and is working to streamline the process. He emphasized that the importance of enhanced use leasing is that it is the only way to

move to assisted living for veterans. Assisted living facilities are viewed as being “housing” not as medical care facilities. Using the enhanced lease program would allow the private sector to provide assisted living facilities for veterans on VA property. VA would, in turn, provide the medical care for those veterans, including outpatient medicine, telemedicine and other types of care.

Affiliate Reactions

Another Commissioner asked Dr. Roswell what VA’s experience has been in Chicago with affiliations. Dr. Roswell said VA could have done a better job of communications with Northwestern. While he believes that Northwestern is now on board with the Chicago program, the lesson is that VHA needs to work closely with its affiliates in making changes.

The Commissioner also asked about the reactions of the house staff. Dr. Roswell said the house staff like working with VA. One reason is the emphasis on the quality of care. Another is VA’s automated patient records system.

Access

A Commissioner noted two instances – Bedford and Livermore – in which the Commission encountered concerns that nursing patients would be moved over an hour and a half away from their current facilities. He expressed the view that it’s hard to argue that the proposal is a clinical improvement issue when VA is moving patients to a nursing home with no hospital. He asked Dr. Roswell why VA didn’t consider maintaining some capacity where the nursing homes are located now. Dr. Roswell said maybe VHA should reconsider those proposals but he also said it is an economic issue. He stressed that veterans don’t want to end their lives in a VA nursing home. They want to be at home with their families and friends. If VHA were to keep the two facilities mentioned open, they would have to be maintained and supported. They would have to be economically viable.

The Commissioner followed up by observing that the process seems to have made decisions before conducting analysis, which he views as being backwards. He said he hopes the cost-benefit analyses, when completed, will support the decisions made.

DoD Collaboration

A Commissioner asked Dr. Roswell to comment on the collaboration with DoD and discuss any problems VA encountered. Dr. Roswell answered that it isn’t a perfect world when it comes to collaboration but the alignment between the Under Secretary for Health and the DoD Under Secretary is better than it was. He said work is also going on at other levels. He said there was DoD input to the CARES process. The real task is to get a vertical alignment of plans, from headquarters down to local levels, on both sides. Overall, Dr. Roswell said he believes things are better than they were.

Access

One Commissioner commented on progress in VISN 12. He said he is a stakeholder there and thinks that what is happening there is a real success story. The realignments that were inconvenient originally are working well now.

The Commissioner also observed that VISN 23 – Iowa, Minnesota and the Dakotas – have some of the highest market shares in the country. There is not a lot of growth potential in this VISN. But in other areas, such as Colorado, there is tremendous growth potential that could be met by establishing CBOCs. He asked Dr. Roswell to comment. Dr. Roswell replied he wasn't sure if the variation is the result of regional differences or the result of VA leadership practices. He noted that where VISN Directors pursued the concept aggressively, there is high market penetration. Similarly, where Directors weren't aggressive, VA doesn't have high market penetration. He said VA needs to know what's going on before it makes further decisions and intends to study the matter carefully. The Commissioner said stakeholders believe access is the number one factor.

Plan Cohesion and Cost

A Commissioner commented that when Dr. Roswell last briefed the Commission, he didn't get the feeling that the Draft National Plan was truly a *national* plan – it seemed more like a collection of VISN plans. He suggested to Dr. Roswell that VHA should try to pull things together and should also try to put numbers on things wherever it can – costs and savings especially.

Dr. Roswell replied that VA is dealing with five-year capital budget projections. There are two ways to achieve the results. One is through efficiency savings, which are projected to be \$300 million a year by 2008. The other is through new revenue streams, which VA is projecting at \$70 million a year by 2008.

The Commissioner also addressed the issue of critical access hospitals. He said the CAH concept is being viewed as a matter of political expediency. The Commissioner said VA needs to have a consistent concept for critical access hospitals across the country. He asked Dr. Roswell what the criteria will be for establishing *new* critical access hospitals in areas where there is no VA facility now. His view is that until VA has criteria for creating new critical access hospitals, the CAH designation will be only a protective mechanism.

Dr. Roswell replied that “small facilities” are addressed in the plan – he believes in Chapter Six. The rationale is spelled out there. However, he cautioned that there may never be a “one size fits all” model for VHA critical access hospitals.

Las Vegas Proposals

A Commissioner asked Dr. Roswell to comment further on the VA proposal to establish a new facility in Las Vegas and shut down its operations at Nellis Air Force Base. The Commissioner said they had heard about possible increases in DoD personnel at Nellis due to new missions as being the rationale for relocating VA operations in the area. However, he also said DoD had provided figures on the impact of moving the VA out of the Nellis hospital and noted that DoD opposes the move.

Dr. Roswell replied there are difficult considerations at work in this case. VHA had to move its outpatient operations off the base to make room for new DoD missions and to accommodate security restrictions on access. VA needs a presence in Las Vegas because it is the fastest growing area for veterans, so it pursued a replacement capability. VA also wants to collocate its

long-term care with the new outpatient facility and the new VA Regional Office, which will be at the same site. So VA decided to propose constructing its own facility as part of the Plan.

Since the Plan was issued, VA has worked with DoD and has come up with an alternate proposal under which VA will continue to operate in the hospital at Nellis. However, going with this plan will result in VA having its outpatient facility, nursing home care and regional office located in one place in Las Vegas and its inpatient care located at Nellis. VA is concerned about this and has a strategic planning effort going on locally to resolve issues. The process is not finished.

CARES Planning Model

A Commissioner asked whether the CARES planning model has been re-run recently. Mr. Halpern replied it had been re-run, but only for enrollment. In response to further questions from the Commissioner, Mr. Halpern said the model was still using a 13-month base period for enrollment and was still using constant enrollment growth rate assumptions. He said that it is necessary to re-validate assumptions every year.

Additional Data

A Commissioner asked whether the new VHA data call would provide data on the economic impact of realignment. Dr. Roswell said he hoped the data will show the actual cost of the proposed realignments.

Stakeholder Panel - Affiliates

**Jordan Cohen, M.D., President
Association of American Medical Colleges (AAMC)**

**Dr. Geraldine Bednash, Executive Director
American Association of Colleges of Nursing (AACN)**

Dr. Cohen stated his organization represents the Nation's 126 medical schools, 400 major teaching hospitals and health systems -- including over 70 VA medical centers -- 92 academic and scientific societies, nearly 100,000 faculty and the Nation's medical students and residents. One hundred seven AAMC member medical schools have formal affiliation agreements with a VA facility, which are vital to the missions of both the medical schools and their VA partners. Academic affiliates are deeply invested in the VA system and, therefore, the CARES process. The VA health care system and affiliated medical schools have been intimately linked since 1946 when the program began. VA maintains about 8,600 full-time residency positions and is the Nation's largest provider of graduate medical education. Further, over 30,000 medical residents and over 20,000 medical students rotate through the VA system every year.

Because of this extensive involvement with the VA system, AAMC members are understandably concerned about the possible need to move if VA relocates or realigns its facilities. The changes proposed in the Draft National Plan can affect many program participants. Even moving inpatient services across town may make it impossible for faculty and residents to move from hospital to hospital, thus reducing coverage and quality of care.

Dr. Cohen reported that medical school dean participation in Commission hearings has generally been limited, which he considers to be a positive sign that they are pleased with the recommendations. The deans have said they felt they were a part of the planning process and are comfortable that their concerns have been heard. Each school is unique. In areas where the deans felt their concerns were *not* being adequately addressed, such as Boston and New York, they offered testimony to the Commission. In other places the deans have expressed positive support. Dr. Cohen's impression is that the overall reaction has been more positive than negative. However, some feel that the recommendations to move some service lines have not taken fully into account the potential affect on medical school education and research programs.

Dr. Cohen also reported that there has been skepticism among the deans about whether the VA's education and research missions are receiving adequate attention in the CARES process. Although patient care is the core mission of the VA health care system, high-quality health care is not possible without vibrant education and research programs. They are indispensable for maintaining VA as one of the best health care systems in the world. The AAMC urges the Commission to scrutinize all recommendations for potential unintended consequences on the education and research programs.

AAMC remains deeply committed to the fundamental core relationship between the VA and academic medicine and would welcome a statement from the Commission ratifying the benefits and value of a close working relationship.

Dr. Bednash said that nursing representatives have testified to the Commission about the effect of the CARES plan on the various regions. Today, she is offering a national perspective.

She said VA is the Nation's largest single employer of nurses and a recognized leader in adopting best practices. The VA medical system provides nurses with training and experience that is of very high value.

Her organization, the American Association of Colleges of Nursing, has signed an agreement with VA that will allow VA nurses to get baccalaureate degrees while working. The program has 2,700 participants at 300 educational institutions.

Dr. Bednash said the VA's clinical placement opportunities are critical for nursing school enrollment. Nursing schools currently have faculty shortages and lack of clinical training sites. This situation is causing qualified candidates to be turned down for admission, causing a nationwide shortage of nurses.

Her organization urges the Commission to ensure VA maintains a strong focus on providing clinical training opportunities for nursing.

Q&A/Discussion

A Commissioner said the time has come to bring to nursing what has been in place for medicine since 1946 – formal affiliations for nursing schools. Another Commissioner agreed, expressing the view that the VA could take advantage of the move to CBOCs to provide clinical opportunities for nurses. Dr. Bednash offered to provide some figures on nurses employed in CBOCs now. She indicated her organization would be very interested in formalizing the

relationship between VA and nursing schools. Among other benefits, it would provide a critical mass for mentoring.

A Commissioner noted that there is more of a firewall between nursing school faculty and the VA than there is on the medical side. He asked whether a formal relationship would reduce such barriers. Dr. Bednash agreed that it would.

Dr. Cohen asked to have added to his remarks the fact that his organization supports the need for new and modernized facilities for research at VHA.

One Commissioner noted that the Commission values very highly the VA's medical school affiliations. For this reason, he has been concerned that the Commission hasn't heard much from the deans. Dr. Cohen replied that this was a positive sign. The Commission would have heard a lot more if the deans were upset.

Another Commissioner asked about the importance of nurses having a baccalaureate education for critically ill patients. Dr. Bednash said a recent study shows that surgical patients experience significantly lower mortality rates in hospitals with higher proportions of nurses educated at the baccalaureate level or higher. The AACN believes that at least 70 percent of nursing staff should have a baccalaureate degree.

Stakeholder Panel – Employee Organizations

**Alma Lee, President, National VA Council
American Federation of Government Employees (AFGE)**

**Dr. Kathy Udell-Martin
National Association of VA Physicians and Dentists (NAVAP)**

Ms. Lee informed the Commission that her organization represents approximately 150,000 Department of Veterans Affairs employees. She said the goal of the CARES process is laudable and necessary, but it is essential that the decisions made to reduce, expand and realign VA's capital assets be data driven. It is also important for the policy decisions embedded in the data projections and the planning initiatives to be transparent.

AFGE joins with those organizations that are concerned with the glaring omission from CARES planning of long-term care, mental health care and domiciliary-based care. It understands that VA is revising its projection model for these key services, but is perplexed that the draft plan nonetheless proposes to close or shift long-term care beds and space for mental health and domiciliary programs. She cited the following as involving long-term care and domiciliary space and having implications for mental health programs: proposed closures of Canandaigua, New York; Brecksville, Ohio; Highland Drive in Pittsburgh, Pennsylvania; and the proposed realignments in Montrose, New York; White City, Oregon; Livermore, California; Walla Walla, Washington; Knoxville, Iowa; and Waco, Texas. She asked how these proposals could be data driven if VA didn't use data projections on long-term care, mental health and domiciliary care.

Ms. Lee said the enrollee projection model shows VA will need an additional 17,357 nursing home beds by 2022, although informal discussions with the CARES staff indicate that revised

projections will be lower. Even if reduced by half, VA would still need 8,678 new beds. Presuming an average of 150 beds per facility, the figures suggest VA should be planning for at least 57 new facilities.

If the VA does not provide in-house care for veterans needing nursing home care or adult day care, they will likely be forced into the Medicaid system. VA provides veterans with nursing home care for only six months – long enough for them to apply for and receive Medicaid. It is imperative that VA have the in-house capacity to offer nursing home care to veterans and not just deposit them into the Medicaid system.

Ms. Lee noted the draft CARES plan increases VA's dependence on non-VA medical care, including long-term care. She questioned the capacity of the private sector to deliver the level of care needed and said it is unlikely the private nursing-home industry will uniformly provide veterans with the high quality care they deserve.

She also noted that VA is currently planning to rely on non-VA providers of adult day care. She said plans call for increasing contract services by over 200 percent. Ms. Lee asked the Commission to caution the VA against turning to non-VA providers for long-term care because there is already a shortage of adult day care centers. She recommended VA develop its own centers and collocate them with VA nursing home facilities.

AFGE is also concerned that a central component of the CARES plan is contracting out primary outpatient and inpatient medical care. AFGE is concerned that VA is being pressed to have the plan conform to OMB's outsourcing initiative. Her organization's members who are health care providers believe contracting out care fragments and disrupts the continuity of care and undermines their ability to treat the whole veteran. She urged the Commission to recommend that the VA plan provide care through VA providers not through the wholesale privatization of medical care or an increase in contracted care.

Ms. Lee urged the Commission to recommend modifying the plan to address the absence of any capital planning for consolidated mail outpatient pharmacies (CMOPs). Policy changes are likely to increase veterans demand for this service. New CMOPs, in addition to today's seven regional CMOPs, will likely be needed. VA CMOP operations are highly efficient and cost-effective.

AFGE notes that the Draft National Plan relies extensively on enhanced use lease options to eliminate vacant space as a result of realignments. Ms. Lee pointed out that as a practical matter VA has had only a handful of successes with enhanced use leasing. Many of the proposals in the CARES plan have been in the works – unsuccessfully – for years. AFGE believes it is premature to rely on this approach. It recommends that where enhanced use leases are included as an option, the proposals should have a time limit and the Plan should have a backup option for the space if the enhanced use lease is not realized within that time limit. AFGE also urges the Commission to ensure that lease agreements are centered on veterans' care and that veterans are guaranteed access to the new facilities.

Dr. Udell-Martin said that NAVAP, consisting of VA physicians and dentists, shares the Commission's goal of improving the quality of health care for veterans. She pointed out that the buildings, surgical suites, examining rooms and equipment her organization's members use each day vary widely, yet all are expected to deliver the same high quality of care. The Draft

National Plan includes many good ideas, but there are areas of concern, including some that result from the “law of unintended consequences.”

Dr. Udell-Martin observed that the dollar amounts included in the plan are “staggering.” While her organization agrees that the facilities changes are important to the future of veterans’ health care, they will be made against a backdrop where every VA facility is struggling with recruitment and retention because VA cannot compete with private sector wages and benefits. While most VISN plans envision the creation of new positions, appropriations are limited. Unless and until Congress is willing to commit to both sides of the equation, fewer providers will be called upon to provide more and more services.

The stock answer is to contract out services into the community. Her Association believes this is neither cost-effective nor continuity-of-care effective. VA physicians and dentists get to know their patients and their individual needs over time. This is not necessarily the case in contracted service situations. Increased oversight of outside contractors is not the answer. Committed employees are the answer and at a considerable savings.

A real attraction for young physicians and dentists is the opportunity VHA provides to affiliate with a university and do research. If forced to reduce research time as a result of short staffing, one of VA’s most important recruitment tools may be lost and the funds for renovation and construction to provide new research space will go under-utilized.

The Association notes with very positive interest the portions of the plan that encourage the use of technologies to improve diagnostics and treatment. It urges the Commission to further recognize the importance of this issue by creating a dedicated chapter in the plan before submission to the Secretary.

Two areas require further study – long-term care and inpatient and outpatient psychiatric care. The Draft National Plan does not reflect the true out-year facilities needs in these areas. Improper planning for long-term care could have a devastating impact on elderly veterans at a time when they have no alternatives. Similarly, handing off psychiatric care projects to the next strategic planning cycle may subject that patient group to uncertainty and unknown risks.

The Association noticed that several VISNs raised concerns about parking structures but there was no discussion of improved space for in-house or consolidated mail outpatient pharmacies. She also said that VA-DoD collaboration and privatization cannot be the sole alternatives to in-house investment for improvement and continuity of care.

The Association’s members position on CARES proposals can be summed up as “where you sit depends on where you stand.” For those whose practices are moved closer to home or become more interesting, CARES will be welcome. For those who must relocate, travel greater distances in rush hour traffic or change positions, the passion they feel for their VHA career may be diminished. She urged the Commission not to lose sight of VA’s human assets as well as its capital assets as it moves forward, lest the employees become victims of the “law of unintended consequences.”

Q&A/Discussion

A Commissioner began the discussion by asking if the employee organizations had any estimate of how many jobs would be affected by the closures and realignments. Ms. Lee said AFGE was looking into the question but won't have good information until implementation plans are developed.

Another Commissioner asked if Ms. Lee's estimate of the need for 17,000-plus new nursing homes came from Milliman data. He noted that the Commission does not have nursing home care on the table for consideration. An AFGE counsel said the FY 03 projection model projects that VA's average daily census for nursing home care will grow from 31,941 in FY01 to 49,298 in FY22, representing an additional 17,357 beds. She discussed the assumptions used in the projection, which are detailed in the AFGE handout, but emphasized that the point is that just maintaining the current number of beds, which is what the Plan does, will not be sufficient to meet future needs.

Following up, another Commissioner said the Commission has been told that the VA estimates do not include the capacity of state veterans homes. He asked if the union figures included state homes. The union counsel replied that all sources, including state homes, are included in the projections.

In response to another Commissioner's question, Dr. Udell-Martin said she would provide the Commission with any facilities-specific concerns her organization has.

Stakeholder Panel – Employee Organizations

**Robert Redding, President, IAM DVA Council
National Federation of Federal Employees (NFFE)**

**Michael J. Boucher, President, National VA Council
United American Nurses (UAN)**

**Mark Bailey, Senior National Representative
National Association of Government Employees (NAGE)**

Mr. Redding, who is a counseling psychologist with Veterans Benefits Administration, said his organization sees CARES as proposing a significant shift in VA health care delivery. Driven by an appetite for privatization, the assumptions used in the National CARES Plan, if realized, will dramatically change how VA delivers health care benefits. However, if they fail, veterans' care will become a slippery slope fraught with potentially differing standards of benefits and services.

One concern is that CARES may underestimate the growth in the number of elderly veterans – the number of veterans over the age of 75 may triple in the next 20 years. Long-term care for these veterans should increase proportionate to their numbers. However, CARES appears to assume a model that privatizes long-term health care for veterans. NFFE believes promises have been made relative to veterans' health care and that veterans have consistently demonstrated a preference for "veteran only" facilities. Privatization is not consistent with this preference.

Other concerns relative to privatizing long-term care include (1) the cost of contracting for long-term hospitalization of psychiatrically impaired veterans; (2) the resource drain resulting from contracting for severe or profound disabilities; (3) the VA has an obligation to provide the absolute best care for our Nation's veterans; and (4) the loss of veterans' expertise in small communities. VA is best served by retaining absolute control of vulnerable veterans' populations, not contracting our critical long-term care to the lowest bidder.

The CARES plan also does not address the potential for upheaval among veterans who are employed by VA, including disabled veterans, female veterans, full-time employed veterans and part-time employed veterans. VA has historically been a champion in providing employment opportunities for veterans. Rural facilities and CBOC closures will adversely affect employment of veterans. Closing VA facilities will undo the progress made and may affect minority populations disproportionately.

The CARES plan may benefit from exploring alternative use scenarios for facilities where excess space exists. Marketing of those facilities should be explored and might benefit any number of state and federal agencies, veteran service organizations or private sector entities. VA should be encouraged to seek creative ways to profit from existing facilities rather than close them.

CBOCs are the lifeline for many senior veterans in rural areas and should be retained as a matter of necessity, particularly in the upper Midwest. In many areas, the best care available to veterans is from a CBOC. CARES should not eliminate any CBOCs and should consider all rural outpatient clinics as "mission critical."

NFFE also believes the CARES plan falls short in addressing long-term psychiatric care for veterans. Data necessary to accurately predict inpatient and outpatient occupancy rates for mentally ill veterans are missing from the plan.

NFFE will continue to review research and planning regarding CARES and recognizes the shifting environment surrounding the plan. It strongly urges that *no* VA facility, including clinics, be reduced until every enrolled veteran receiving treatment or dependent upon such a facility is satisfactorily redirected and reports satisfaction with privatized health care services.

Mr. Boucher noted with satisfaction that nearly every VISN-level plan mentions that employee and union input was actively solicited. He understands the Commission has already heard from many VA nurses and from his organization's local chapters around the country.

The key concerns he hears are: facility closures and service realignments; linking nurse staffing with facility services; outsourcing health care; incorporating safety, health and environmental concerns; parking; and emergency preparedness and response missions.

Regarding closures and realignments, Mr. Boucher recognized that very few facilities are proposed for closure, but said nurses are concerned that patients may have to travel significant additional distances to get VA services because of realignments.

He recognized that the CARES Commission is not primarily concerned with staffing but pointed out that realignments may not put the VA facilities where the nurses are. RNs often change employers if their nursing specialty is no longer required or the working conditions no longer

meet their needs. Staffing shortages already exist in a number of VA facilities, including some of the facilities recommended to assume additional workload under the CARES plan.

His organization believes VA now provides veterans with the highest quality health care. Contracting out that health care may reduce the quality and may not serve the veteran best. Many veterans are less than satisfied with community-based health care and would prefer a VA facility. His organization would prefer to see outsourcing of nursing care kept to an absolute minimum for these reasons.

Workplace safety, health and environment concerns are top priority for nurses. The plan makes no mention of such innovations as state-of-the-art patient lifting devices and other technologies, even though they could affect the size requirements and cost of new construction.

Parking is a concern not only for nurses but for patients. Reducing access time and waiting times for an appointment should be accompanied by sufficient parking. Nurses are frustrated when patients arrive late for appointments due to parking difficulties and are hard pressed to find parking themselves to arrive on time for work. The situation borders on critical at several facilities. The CARES plan will increase the problem by increasing workload at several facilities.

Nurses are also concerned about the ability to carry out VA's "fourth mission" – backup to DoD and the Department of Homeland Security in the event of war, terrorism or natural disaster. The concern is that VA is over committed in relation to both hospital beds and direct care nurses. His organization estimates that there are fewer than 3,000 vacant beds in the entire VA system to accept casualties, and further decreases are being recommended in several VISNs. Mr. Boucher said he is also concerned about the lack of infrastructure support for decontamination and isolation facilities, even at the primary receiving center hospitals. VA may not be fully capable of responding with hospital facilities or staff to disasters, biological events and related emergencies.

Mr. Bailey said his organization has great concern that there will be a mass exodus from the military in the near future. VA should be ready to deal with a surge of new veterans, but it has been continually downsizing since the mid-1990s. It is also concerned about VA contracting out health care services to contractors who do not provide services that are tailored to veterans and their needs.

He said CARES does not enhance succession planning. The CARES process did not include lower-level employees.

NAGE supports the view that the facility enhancements proposed by CARES must be in place *before* any closures, realignments or changes in how services are provided can be contemplated. NAGE supports CARES only to the extent the plan provides for quality patient care.

His organization recommends the establishment of an oversight and advisory board as part of the implementation process.

Q&A/Discussion

One Commissioner assured Mr. Bailey that the Commission had heard from union representatives at all its hearings. Mr. Bailey said the unions are well versed on CARES, but the employees at large have not been informed as to what is going on and haven't been given a chance to participate in it.

Another Commissioner asked about the views of the panel toward contracted care outside the VA system. Mr. Redding said his organization's concern is that VA not close existing CBOCs. Mr. Bailey said there are certain times when it makes sense to contract out, but believes VA should involve the unions in developing the contracts.

Stakeholder Panel – Mental Health Organizations

**Ralph Ibson, Vice President
National Mental Health Association (NMHA)**

**Roscoe Swann, Board Member
National Alliance for the Mentally Ill (NAMI)**

**Dr. Miklos Losonczy
Co-Chair, VHA Seriously Chronic Mentally Ill (SMI) Committee**

Mr. Ibson reminded the Commission that his May testimony urged the Department to defer implementation of CARES until it validates the planning model for inpatient and outpatient mental health care. At that time, expert testimony indicated that the model is badly flawed.

The authors of the Draft National CARES Plan published on August 20 characterize it as “a systematic assessment of the future needs of veterans” and describe the basis for it as a “tool of unprecedented precision” employing “state-of-the-art methodology.” Even so, the plan acknowledges that “there was a general consensus that mental health projections needed to be further studies and refined.”

Remarkably, the draft CARES plan – admittedly *blind* to the magnitude of the future needs of veterans with mental illnesses – nonetheless proposes sweeping changes in VA mental health service delivery, including closures of several psychiatric facilities, transplantation of mental health services from one facility to another, and contracting for services. The plan appears to be saying that VA is plowing ahead even though it lacks reliable data on future mental health needs. Mr. Ibson said this is like initiating elective surgery in the dark or launching a manned space flight without examining engineers' repeated warnings of potential danger.

The National Mental Health Association is not opposed to change in VA. The dynamic nature of health care, the age of VA's health care infrastructure and demographic changes all argue for robust planning and for re-examining the missions of VA facilities and the siting of VA service delivery.

Scientific understanding of mental health has seen dramatic advances. But the President's New Freedom Commission on Mental Health observed in its July report that “far too often, treatments and services that are based on rigorous clinical research languish for years rather than being used effectively at the earliest opportunity.” Clearly, some of these advances have not reached veterans who rely on VA for care. The Commission noted that too often mental health care is

focused on managing symptoms rather than on facilitating recovery and building resilience. The central theme of the Commission's report and recommendations is that *people can recover from mental illness*. That is, they can live, work, learn and participate fully in their communities. To achieve this promise, every American must have access to the most current treatments and best support services. Our goal for veterans can be no less.

Just as VA planners need a far more reliable methodology to project future mental health needs, it is critical that they take account of the profound changes underway in mental health service delivery. Those changes have not fully taken hold in VA and it is not apparent that VA planners have incorporated the new "recovery paradigm" into the CARES process.

The August CARES plan provides only a bare summary of a multitude of sweeping proposals – just a few terse sentences to describe a facility closure or shift in services. It is striking that the consolidations and shifts proposed for mental health care generally reflect a plan to transfer or shift the location of services. The underlying assumption seems to be one of maintaining current service delivery. The plan proposes dramatic changes in the siting of VA mental health care without providing detailed justification, information on alternatives that were considered or any specificity or safeguards regarding future access to mental health care. The basic message appears to be "trust us." Given a system with broadly decentralized authority, the plan requires veterans to bestow trust across a large cohort of decision makers. For those who witnessed and experienced the erosion in VA mental health and substance abuse services since 1996 – notwithstanding a law intended to assure maintenance of services – a "trust us" message has a decidedly hollow ring.

The CARES process and the "realignment" plans it has proposed raise real fears of further erosion in service levels and quality. Moreover, Mr. Ibson's organization fears that a planning process aimed at meeting future needs is destined to fail if its thinking is grounded simply in maintaining delivery of services now in place and if it employs no effective mechanism to engineer needed changes. Surely this plan understates future needs. His organization knows from the work of the SMI Committee that access to VA mental health services is highly variable across the country and there is a huge need to expand VA mental health care capacity. If VA is to provide needed services to veterans with mental health needs and conform its service delivery to what we know to be state-of-the-art care, then the standard of "maintaining current services" is not an acceptable framework.

In too many places, maintaining current services means symptom management rather than fostering recovery. Recovery from mental illness implies more than providing just medical care. Recovery-oriented care may also require psycho-social rehabilitation, case management, supported employment, housing, independent living and social skills training and peer support services.

VA represents a unique safety net for veterans with mental illnesses. Our public mental health system is in shambles and limitations in both the Medicare program and worker-provided health insurance routinely deny individuals access to needed mental health services. With the enormous barriers erected by these other systems, veterans with mental illness – large percentages of whom are service-connected – have long had a special need for strong VA mental health programs.

Notwithstanding the important role that mental health care plays in the VA – a role codified in statute – VA has not addressed fundamental issues surrounding equity of access. Veterans face enormous variability in the availability of mental health and substance abuse services depending on where in the country they live and on the severity of their disorder. These overarching concerns do not appear in the CARES plan.

A facility realignment process that proposes major changes in mental health service delivery without reliable data on future mental health needs is fundamentally flawed. The perceived imperative to implement a facility realignment process in accordance with a predetermined timeline must not be permitted to overtake the imperative to “get it right.” VA should defer implementation of any CARES plan until it has developed and validated a reliable planning model for determining veterans’ future mental health needs.

NMHA believes VA must give high priority to developing a credible methodology for determining future needs of veterans. The model must take into account the long-constrained mental health care utilization in the VA. It must also take into account the changing paradigm of mental health care, recognizing recovery as an overarching goal. This important work cannot be done “on the cheap,” relying alone on the SMI Committee, which is made up of VA professionals who have primary responsibilities at their individual medical centers.

At some point there will be a sound basis to recommend facility realignments and sound data may well support closing a number of facilities and better integrating mental health services. It is important that such a process provide very detailed plans for each realignment rather than the sketchy information now available. VA must also develop and employ safeguards built on the experience of de-institutionalization in 1996 and thereafter. We learned painful lessons when VA closed mental health and substance abuse beds and failed to redeploy those dollars into community-based mental health and substance abuse care. We must not close psychiatric facilities and again fail to reinvest savings. Verbal assurances will not be enough. Serious consideration will have to be given to mechanisms like “fenced funding” to assure that veterans mental health needs are not again short changed.

Mr. Swann said his organization, the National Alliance for the Mentally Ill, is a grass roots self-help organization that was founded in 1969. Hundreds of thousands of volunteers participate in over a thousand organizations in all fifty states.

His group is concerned that VA is proposing facilities closing and realignments when mental health programs need to be increased. VA should not make the same mistake the states have made – closing mental health facilities and shifting the burden to outpatient treatment facilities that aren’t adequately funded.

His organization notes that VA funding for severe mental illness is inadequate and has not kept up with inflation.

He also said that if VA facilities are closed or relocated, not only the veterans but also their families would be adversely affected. Many would be able to travel long distances to get care, for example.

His organization recommends establishing one-stop comprehensive community care centers that would give veterans the ability to access a full range of needed services, including case

management teams. He would also advocate the establishment of “veteran to veteran” selfhelp programs.

Dr. Losonczy told the Commission that the SMI Committee believes that the VA system is the best in the country, even with all of its warts. His comments are intended to ensure that it becomes even better as CARES moves forward.

The SMI Committee has been involved in CARES only since September 2002, when it began analysis of the CARES model and its application to mental health services. Since then, the SMI Committee has been engaged with the National CARES Program Office and Milliman in working on the CARES data model for mental health. As a result of these discussions, it was learned that external private-sector benchmarks exist for only 65 percent of the VA mental health outpatient workload – not the 100 percent assumed by the current model. For the other 35 percent, the new model will use VA-only benchmarks. For these VA-only services, benchmarks will be set at the 85th percentile. To project supported employment, family psychoeducation and peer counseling services, policy decisions will be required because there are resource implications. These are now awaiting decision. The status of the work group recommended to develop projections for long-term psychiatric beds is unclear. The target date for completing the new model is now April 2004.

However, the extent of the underestimates of demand for mental health services and the ongoing revision of the mental health projection methodology were not clearly denoted in the Draft National Plan. Dr. Losonczy said the actual demand for mental health services was much higher in 2001 than the projections suggested – the projections were short by 1,650,000 visits. For 2012, the total mental health demand is projected at 10,089,026 visits. The “gap” for 2012 – the difference between the current projection and a more realistic projection – is 4,603,659 visits. This is 84 percent higher than the baseline year – not a small correction.

Since June, the SMI Committee has been waiting for the data runs for the VA benchmark corrections. Private sector projections will only change modestly due to an age cohort adjustment. Since we know there is a variable unmet need (due to higher inter-VISN variability), the VA benchmark visits will also increase over the 2001 baseline. Additionally, the recovery-based programs are awaiting policy decisions, as already noted.

Current indications are that the cost of meeting all mental health needs, not just outpatients, for veterans with serious mental illnesses will be 81 percent higher than was provided in FY 2002. The President’s New Freedom Commission recommendations are very consistent with the SMI Committee’s recommendations in its annual report for the past four years. The SMI Committee is gratified that VHA has established an implementation group for the New Freedom Commission report.

The Draft National Plan projects gaps in inpatient psychiatry care, which includes acute psychiatry, acute substance abuse, long-term psychiatry and residential rehab programs. However, long-term psychiatry and residential beds were taken off the table for consideration in December (about 40 percent of all psych beds) even though they are included in the projection figures in the Draft National Plan.

The SMI Committee is concerned that these data, even though they are known to be bad, are being used for planning. The Committee does not understand how any statement can be made

without first having a corrected model. Moreover, the projected drop in demand for services shown in the Plan is mostly due to assumptions about the use of services as veterans age and on enrollment mix contributions. Both assumptions may well not be valid.

The SMI Committee is concerned that the impact of underestimated mental health demand projections and the method of their correction are not addressed in the Plan. It is also concerned about who will ensure follow through when corrections are made to the model. Further, the realignment of 20 facilities proposed in the Draft National Plan bypassed stakeholder feedback, which may have resulted in poorer quality plans. The Committee is also not clear as to what data if any were used in the proposed consolidations since this phase of CARES was not to include long-term psychiatry beds and reductions in outpatient mental health.

Dr. Losonczy stressed that the SMI Committee does *not* oppose the concept of integrating neuropsychiatric facilities with nearby tertiary care facilities. They should have been that way all along. Its only real concern is the ability to continue at least at the current level of access and services after a consolidation and, ultimately, to meet the needs of veterans equitably and fully throughout the country. The current Draft National Plan is not sufficiently detailed to assess the impact.

In regard to domiciliary care beds, the draft projection model has just been completed, but it may be significantly modified before it is finalized. Dom projections are important to the Committee because a similar model may be used for mental health residual long-term services and over 90 percent of dom users have a mental health diagnosis. The model projections use the 85th percentile of the best VISN for beds per at risk population, segregated by over-65 and under-65 age groups. This seems fine to the SMI Committee. The at-risk population is defined by veterans at or below the national definition of the poverty line.

SMI concerns are that the model recommends building based on the FY 2022 projections. It is unclear how VA will meet the gaps between the current demand for dom beds or between the current number of beds and the projected demand in 2022. The model proposes contracting for services. The Committee is also concerned that the poverty line does not include a geographic adjustment using cost-of-living indexes for each market. There are substantial variations in the cost-of-living from one geographic area to another.

The Committee is further concerned that the model does not address the eight VISNs whose need for dom beds is projected to fall by FY 2022, even though they are higher now than current services. Also, the model does not use estimates of rates of homelessness in different markets. Instead it uses only the at-risk population which, although it may be the best that can be done, is limited.

The SMI Committee is very pleased with the inclusive nature of the CARES process for fixing the current model. However, it is concerned about what will happen when the CARES Commission completes its work before the new model is available in April 2004 and about who will ensure that the corrected model is faithfully implemented. Accordingly, the SMI Committee suggests that the Commission consider recommending the establishment of a Secretary-level advisory group to independently assess the validity of the mental health model when completed and the fidelity of the annual plans post-CARES.

Q&A/Discussion

One Commissioner asked Dr. Losonczy if he could provide a plain-English narrative summary of his presentation and he agreed to do that. The Commissioner also asked about Dr. Losonczy's statement that the Committee is not objecting to the notion of consolidating mental health units with tertiary care facilities. Dr. Losonczy said the Committee would not object as long as proper consideration is given to access. The Commissioner further asked if the SMI Committee could serve as the Secretarial-level committee being recommended. Dr. Losonczy said "possibly" but that it might be better to have a different group.

Dr. Losonczy was asked by a Commissioner about his assessment of a particular facility, but said he was not familiar enough with that facility to comment. He did say that the Committee believes that VA does a very good job overall, but that the variability is enormous.

Another Commissioner said the hearings raised piercing questions about mental health. He is hopeful that as the data improve the issues and needs will become clearer. The Commission will be looking at the proposed consolidations carefully to see if they are the right thing to do.

A Commissioner asked about the role of CBOCs versus inpatient facilities for treating mental illness. Dr. Losonczy replied that the vast majority of mental illnesses could be treated at CBOCs.

Administrative Matters

Chairman Alvarez acknowledged the desire of several Commission members to hear from the VISN 12 Director (Chicago) about the CARES pilot experiences. He said the problem he is facing is one of time. The agenda for next week's meeting is already busy.

Mr. Larson reviewed the meeting schedule. There will be a three-day meeting next week to make initial decisions and a three-day meeting in November (19-21) to finalize the decisions and review recommendations. He and the staff have been looking at whether adequate data will be available for decision making. Data will be available for everything except the proposed realignments. The realignment data – which is cost data – won't be in before October 22 at the earliest.

A Commissioner commented that she did not want people to criticize the final product because the Commission didn't have enough time to do it right. Another Commissioner suggested that the Commission should build fallback positions into its decision making. He said he, too, wants the report to be the best the Commission can do. If that takes more time, the Commission should take it.

Another Commissioner said the Commission is supposed to give its opinion of what's in the Draft National Plan. Mr. Larson said there is no documentation or audit trail to show what data were used to make specific recommendations. But the staff is compiling its own list of the initiatives to be decided by the Commission. The Commissioner cautioned the staff not to get caught up in the inadequacies of the NCPO.

The meeting was adjourned by the Chairman.