

**Statement by Senator E. Benjamin Nelson**  
**Cares Commission Hearing**  
**Thursday, September 4, 2003**

I would first like to thank Everett Alvarez, Jr. the Chairman of the CARES Commission for inviting me to submit testimony commenting on the draft national plan released by Secretary Principi and Under Secretary for Health, Dr. Roswell. I appreciate the attendance of four CARES Commissioners including Vice Chairman Vogel. Since, the announcement of the merger of Networks 13 and 14 into VISN 23, the Midwest Health Care Network, we have observed the need to include the concerns of individuals directly impacted by these sorts of decisions. I thank you for conducting this open hearing as this is an important issue and by including such panels of Veteran Service Organizations, Network Leadership, Employees and VA Affiliates and Collaborators, we make a step in the right direction by showing that the CARES process is interested in the concerns of those directly affected.

As a member of the U.S. Senate Veterans' Affairs Committee, I take pride in helping to ensure our nations veterans receive health care service they deserve and have earned. I have reviewed both VISN 23 recommendations for enhanced care as well as the draft national plan, and I would like to take a moment to express some concerns and highlight what I and many of my constituents believe to be of highest priority.

**Community Based Outpatient Clinics**

Currently, only 51% of Nebraska Veteran enrollees are within the VA driving guidelines for Primary Care; the guidelines being 30 minutes for urban and rural areas and 60 minutes for highly rural areas. In order to resolve the gap in access to outpatient care, VISN 23 established a planning initiative to develop Community Based Outpatient Clinics (CBOC) in 1) DOD/Bellevue, NE; 2) Holdrege, NE; 3) O'Neill, NE; 4) Shenandoah, IA; and 5) increase the capacity at the existing CBOC in Norfolk, NE. According to the CARES planning initiatives and market plans, the rationale for selection of these cites were based on the population enrollees that lack access in these areas.



For example, according to a CARES Planning Initiative Draft (12/19/02) in and around Phelps County (Holdrege) there are approximately 4,300 enrollees with zero % access. If you are an enrollee living in Holdrege, to receive primary care, you have to either drive 85 miles to North Platte or 100 miles to Grand Island. Another area of concerns is in and around Madison County (Norfolk) where approximately 2,900 enrollees are without access. If you are an enrollee living in Norfolk you have to drive 120 miles to Omaha to receive primary care as the local CBOC in Norfolk is not accepting new patients.

By establishing these CBOC's it would increase the access level to 64% of enrollees by 2012 and 67% by 2022 with the target being 70%. During the network review process, there was wide support exemplified with 80% of stakeholder comments agreeing and supporting this proposal.

Therefore, I was concerned when the draft national plan classified these CBOC initiatives in the priority 2 category. To qualify as priority 1 a market must demonstrate a larger future outpatient capacity gap, large access gaps and the number of enrolled who do not meet access guidelines is greater than 7,000. According to 2001 VA data, Nebraska has 52,022 enrollees and only 51% of these meet the access guideline, leaving 49% or 27,696 total enrollees outside of the driving guidelines. The national plan figures by dividing 27,696 by the 4 proposed CBOC's, you come up with the number of enrollees not meeting access guidelines as approximately: 6,925 enrollees—just under the 7,000 mark to qualify for the priority 1 category.

Many believe by placing all of these CBOC proposals effectively in the priority 2 category that rural areas of Nebraska will not see improvements in the near future

and will be penalized in comparison to more urban areas with a larger number of enrollees. Once again, 49% of Nebraska enrollees are outside of the driving guidelines; meaning the Department of Veterans' Affairs is providing access to Primary Care only half of the time for Nebraska's Veterans. I find this statistic deeply troubling. Nebraska veterans, who sacrificed just like other veterans, should not be penalized because they live in a densely populated area. Therefore, I support the network proposal and advocate that these 4 CBOC recommendations be included in the priority 1 category.

### **Realignment of Small Facilities (Cheyenne & Hot Springs)**

The national plan included recommendations to transition some smaller facilities from Acute Care Hospitals to Critical Access Hospitals. I am of the understanding that the VA is currently using the Medicare definition of a CAH: 1) must have no more than 15 acute beds, and 2) cannot have lengths of stay longer than 96 hours and 3) maintain a strong link to their referral network. The national plan proposed that the CAH model be implemented at the Cheyenne VA Medical Center (VISN 19) and at the Hot Springs VA Medical Center (VISN 23).

As you may know, there 921 Nebraska veterans in Banner, Cheyenne, Garden, Keith, Kimball and Scottsbluff counties that utilize the Cheyenne Medical Center in Cheyenne, Wyoming. In the past fiscal year these veterans were served by 3,578 visits with an average length of stay for acute care at about 130 hours – above the 96 hours threshold for CAH model. The national plan's focus for this facility is to maintain acute bed sections, develop more restrictive parameters for types of in house surgery procedure and close all ICU beds. The recommendation to convert this facility to a CAH model however *was not* included in the network proposal. Consequently, I have received a significant amount of feedback from local veteran service officers, organizations, facility employees and veterans concerned that this recommendation was suggested late in the CARES process leaving little feedback time for shareholders and many veterans feel they will see a continual decline in services at the Cheyenne Medical Center.

I have also been contacted regarding the Hot Springs Medical Center, however, not to the degree as the previous proposal. Of the approximately 6,900 veterans in the Northern Panhandle of Nebraska (Box Butte, Cherry, Dawes, Grant, Morrill, Scottsbluff and Sioux counties) 2,590 are registered at Hot Springs with an average length of stay for acute care at about 72 hours – conforming to the CAH model. The focus for this facility is to decrease bed numbers and increase contracts and referrals. If the recommendation is accepted the Black Hills System will suggest that any acute procedure that cannot be performed at Ft. Meade *may* be contracted

at either Rapid City Regional Hospital or another hospital capable of doing the procedure. This would open the door for the patients seen at the Scottsbluff clinic, for example, you have treatment at Regional West Medical Center. This would prove positive for many of Nebraska veterans and although there were concerns of downsizing the facility; there is a clear need for continues inpatient services based on the local domiciliary home and state veteran's home both located on the Hot Springs Campus.

Currently, with forces deployed all over the world including Afghanistan and Iraq we must ensure that the veterans' benefits are not just for today's veterans but for the vets of tomorrow. We cannot cut corners on providing high quality care to those men and women who have bravely served our nation. It is our responsibility to ensure that veterans receive the health care services they deserve and have earned.

Once again, I thank the Commission for holding this public hearing and I extend my appreciation for your efforts on behalf of Nebraska's Veterans.

**LANE EVANS TESTIMONY**  
**Comments on National Draft Plan for Capital Asset Realignment for**  
**Enhanced Services (CARES)**  
**VISN 23**

**General:** VA has not addressed the needs of veterans with serious mental illness or those in need of long-term care in this phase of CARES. VA immediately dismissed the outcome of its own long-term care model that projected a need for 17,000 nursing home beds by 2022. The Administration also lacks a plan to prioritize and call for the significant investments necessary to make the promised enhancements in its Plan.

**Iowa Market**

**Primary Care:** The Iowa market in VISN 23 has and will continue to have too many counties that do not meet VA’s access standards under the National plan. While the addition of new clinics will help the market better meet access standards for primary care, some of the locations selected do not reflect the concentrations of enrolled veterans in the market. Some counties, including Whiteside, IL, already have enough veterans enrolled who are not within VA’s access standard to constitute a panel size (about 1200 veterans) that would justify the creation of a community-based outpatient clinic (CBOC). None of Whiteside’s 1,942 enrolled veterans meet VA’s access standard. It is the largest enrolled veterans’ population in the Iowa Market for which a CBOC does not exist and is not proposed. CARES Baseline Access data from VA indicates that Whiteside’s enrolled veteran population equals or exceeds the populations for counties where VA now has clinics or has proposed clinics. The table below shows how Whiteside’s population compares with other counties for which new clinics are proposed. In addition, Clinton County, IA, which is adjacent to Whiteside County, seems to have been overlooked in options to increase the market veterans’ access.

<b>County</b>	<b>Proposed CBOC</b>	<b>Numbers of Enrolled Veterans (Enrolled Veterans Not Meeting Access Standard for Primary Care)</b>
Linn County, IA	Cedar Rapids CBOC	3980 (3017)
<b>Whiteside County, IL</b>	<b>N/A</b>	<b>1942 (1942)</b>
Marshall County, IA	Marshalltown CBOC	1941 (1941)
<b>Clinton County, IA</b>	<b>N/A</b>	<b>1607 (1459)</b>

Wapello County, IA	Ottumwa CBOC	1262 (1262)
Carroll County, IA	Carroll CBOC	620 (620)

Many other counties within the market have fewer than 70% of enrolled veterans who have access to primary care.

VA is touting that, nationally, CARES will ensure that 74% of its veterans meet its access standard for outpatient care—its planning goal for access was meeting the goal for 70% of enrolled veterans. Currently, only 44% of veterans in the Iowa market meet VA’s access standard for primary care. With the addition of the proposed clinics, the market will still only address about half the enrolled veterans’ needs for accessible primary care, relegating veterans in this market to a much lower standard of access than most of the nation’s veterans will enjoy. I hope that the Commission will share my view that this is unacceptable.

**Acute Hospital:** The National CARES Plan aims to improve access to hospital care from its current 72% to 84% of VA’s enrollees. In the Iowa market, 42% of those enrolled meet VA’s access standard for acute inpatient hospital care. Both the network and national plans aim to increase the percentage of enrollees meeting the access threshold to 70% by contracting with local hospitals at four different sites including Cerro Gordo, Scott, Dubuque, and Black Hawk Counties in Iowa. While a significant improvement for these veterans, this initiative will only bring the standard of care for Iowa market veterans to the average level available to veterans elsewhere in the nation *right now*.

As with assessing the market needs for primary care, the CARES Area Market Planning (CAMP) Team that assessed contract sites also overlooked Western Illinois in its planning initiatives for acute hospitalization. The table below shows that some of the market’s counties in Illinois with much larger enrolled veterans populations were passed over in favor of Iowa counties with far fewer veterans who failed to meet the access standard. One of the most interesting examples is the decision to provide contract care to veterans of Scott County, IA. VA’s baseline access data demonstrate that 95% of these veterans meet VA’s access standard for acute hospitalization as compared with only 34% in adjacent Rock Island County, IL, right across the river. As the table below demonstrates several other counties—Adams, Whiteside, Knox, and Henry Counties in Illinois and Webster and Clinton Counties in Iowa—with large enrolled veteran populations remain underserved in the Plan.

<b>County</b>	<b>Number of Enrolled Veterans (Enrolled Veterans Not Meeting Access Standard for Acute Hospital Care)</b>	<b>PROPOSED AS CONTRACT SITE?</b>
Black Hawk County, IA	3052 (3052)	Yes
Dubuque County, IA	2828 (2828)	Yes
<b>Adams County, IL</b>	<b>2709 (2709)</b>	<b>NO</b>
<b>Rock Island County, IL</b>	<b>3200 (2112)</b>	<b>NO</b>
Cerro Gordo County, IA	1943 (1943)	Yes
<b>Whiteside County, IL</b>	<b>1942 (1942)</b>	<b>NO</b>
Webster County, IA	1930 (1930)	NO
<b>Knox County, IL</b>	<b>1760 (1760)</b>	<b>NO</b>
Clinton County, IA	1607 (1546)	NO
<b>Henry County, IL</b>	<b>1283 (1283)</b>	<b>NO</b>
Scott County, IA	3158 (158)	Yes

In order to improve access to acute hospitalization, the Commission might recommend additional initiatives. One alternative is identifying additional sites that will have access to local hospitalization by contract. Depending upon the expected census, there could be a second innovative alternative in partnering with a community provider to provide “critical access” hospital care in VA-operated beds. Establishing such a relationship in Galesburg (Knox County), for example, where VA already offers a community-based clinic located near Cottage Hospital, which VA already uses for some ancillary services, would provide better access to veterans in nearby Rock Island and Henry Counties. In this arrangement, VA might have the critical mass necessary to operate VA beds and could negotiate discounted rates for ancillary services with a partner.

### VISN 23

**Specialized Care:** Public Law 104-262 requires VA to maintain the capacity of certain specialized services such as those for mental illness, homelessness, blindness, spinal cord injury and prosthetics. Since Congress has dated

information about the maintenance of capacity in VA's specialized programs, the following comments are based on the Capacity Report for 2001.

I am pleased to support the Plan's proposal to open a new Spinal Cord Injury center in Minneapolis. Minneapolis already has a strong outpatient clinic and this new center will provide better access to specialized inpatient programs for spinal cord injury to many of the veterans served by the network.

In the most recent Capacity Report available to Congress, outcomes for VISN 13 and 14 are reported separately—the data was collected before the networks integrated—so comments refer to these former networks which now comprise VISN 23. In addition, both VISN 13 and 14 made progress in increasing the numbers of individuals served and the dollars committed to the care of veterans with spinal cord injuries over the time studied in our most recent report. Also of note, VISN 13 was making progress with its traumatic brain injury services, but VISN 14 appears to have wiped its program out in FY 2000.

While VISN 13 did a fairly decent job maintaining the capacity of its programs for seriously mentally ill veterans, VISN 14's performance in maintaining both the number of individuals treated and the dollars committed to specialized programs for psychotic, substance abuse, and post-traumatic stress disorder patients has been abysmal. Over the studied time period the VISN made progress in only one area—the number of homeless veterans treated—and even in this category the dollars committed to homeless programs dropped. Changing the mission of the major psychiatric facility in the network—Knoxville—may further damage these programs. In order to ensure this does not happen, Des Moines *must* have its infrastructure intact and available before Knoxville closes its services to ensure that more seriously mentally ill veterans do not fall between the cracks.

VISN 23 has minimal opioid substitution programs available. While VISN 13 was making some progress with implementation of Mental Health Intensive Case Management programs and outreach to the seriously mentally ill across the network, VISN 14 had only 1 team. Veterans with dual diagnosis should also be targeted with a broad array of services to meet their needs, including outpatient and inpatient substance abuse treatment programs, residential treatment programs, and inpatient treatment options.

I am supportive of adding blind rehabilitation outpatient specialists at the sites of care delivery in the network. The Commission ought to request further details

from the network about how it intends to address specialized programs for the blind for its enrolled veterans.

**Long-Term Care:** Public Law 106-117 requires VA to maintain VA nursing home beds at the level that existed in FY 1998. The Committee on Veterans Affairs is actively overseeing VA's compliance with this law despite the fact that VA overtly left response to veterans' long-term care needs out of this phase of CARES. It is my hope that this plan will allow VISN 23 to continue to serve veterans with needs for nursing home care or alternative long-term care services and that it gives priority for excess property to assisted living and community-based organizations addressing homeless veterans needs.

**Other:** The National Draft CARES Plan calls for a major restructuring of the Knoxville and Des Moines VA Medical Center campuses. I believe that the Commission would have benefited from hearing from veterans and other stakeholders about this proposal closer to these care delivery sites. It is disappointing that Commissioners may miss the opportunity to hear a variety of points-of-view about this integration because it is holding its closest hearing on this matter in Omaha, Nebraska, more than 2 hours away from Des Moines.