



STATE OF WASHINGTON
DEPARTMENT OF VETERANS AFFAIRS

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September 16, 2003

Everett Alvarez Jr.
Chairman, Capital Asset Realignment for Enhanced Services
U.S. Department of Veterans Affairs
Washington D.C., 20420

Dear Chairman Alvarez:

On behalf of the Washington State Department of Veterans Affairs (WDVA), I respectfully submit the following comments to you and the CARES Commission.

Washington State is the home of more than 670,000 veterans and the goal of WDVA is to ensure services are available to meet their current and future care needs. The basis for projecting these needs, whether by WDVA or by the VA, is data on veteran population and the enrollment figures. After contending for years that the VA's data under-represented the population in Washington State, the 2000 U.S. Census verified that Washington's population has grown over the past decade, in spite of a national decline.

The years of under-representing the veteran population have led to other inequities that are perpetuated through the VA system and the CARES processes. VISN 20 projections for enrollments, funding, and need for facilities are each based on artificially low projections. When coupled with the elimination of outreach programs the result is even lower utilization by the veterans community and continually lower enrollments, despite an increasing veteran population.

My testimony will address several specific areas within the VISN 20 Proposal as well as the use of data to project demand for care.

Projecting Enrollment:

I am concerned about the VA's processes that fail to factor in the real demand for veteran's health care in Washington State. The VA has used artificially low numbers that are based solely on current enrollment. Again, this is not representative or reflective of the real demand for veteran's health care. Projections based on current enrollment will also create a system that is ill-prepared to handle the demands of the future. The CARES process must recognize that Washington's veteran population grew by 4% from 1990 – 2000 while the national veteran population declined by 5%. While the VISN 20 did update its population and enrollment

projections based on the most current Census data, the VA has yet to update its database with 2000 Census information.

In addition to the basic population calculations, I have concerns with the method used by the VA to assess a state's capital requirements. The number of veterans currently enrolled is the basis for future projections; however, in Washington, only 11% of the state's veterans are active users of the VA Medical Centers. One reason is a lack of outreach to locate veterans eligible for care. As one example, the VA Puget Sound Health Care System recently discontinued a partnership with WDVA to locate veterans in need of care. Officially, the reason was a lack of funding; however, I believe part of the reason was a desire by the VA to keep enrollments down, which in turn keep enrollment projections down and keep budgets down.

To correct the inequity of basing future capital needs on current enrollment numbers, the CARES Commission needs to take into account the pattern of growth in Washington's veteran population over the last decade and the impact the economy has on the provision of health care services. The process should evaluate how the remaining capital facilities and the reallocation of resources made available by the CARES process are aligned to meet this growing demand.

Another way to examine the distribution of resources within the VA is to examine the VA expenditures in all states. I have long contended that citizens in Washington State do not receive an equitable share of the federal tax dollars they pay. Washington State is now ranked 12th in veteran population. While Washington may be 12th in population, its veterans rank 30th in total VA expenditures. The CARES Commission must recognize that Washington State is already receiving fewer resources than it's population dictates and aim to realign resources in a more equitable manner. (See attached VA Expenditure Information.)

Access:

I am greatly concerned about the rural areas of the state with significant need and a lack of VA facilities or services to meet their need. These areas are grossly underserved and have high concentrations of minority veterans, particularly Native Americans and Hispanics. Again, the lack of outreach has served to further disenfranchise veterans who are not fortunate enough to live near a VA facility.

The VISN 20 Proposal aims to, "Increase the primary care outpatient services in three markets and at all care sites through planned CBOC and DoD joint ventures..." (Source: Appendix A-National CARES Plan). However, the plan does not adequately address the need for care in rural and remote areas of the state. Veterans in areas such as Bellingham and Leavenworth/Wenatchee have long advocated for a CBOC or other type of contracted primary care in their region. Currently, veterans must overcome the obstacles of extremely long driving distances and harsh weather conditions, to receive basic primary care. The CARES Commission and VISN 20 have the opportunity to address this imbalance by ensuring that a CBOC or other cooperative agreement with local providers is in place. As our veteran population ages and becomes increasingly frail, so will the urgency of this issue.

According to the Millennium Health Care Act, states were directed to develop CBOCs. Washington State was slated for eight CBOCs; yet, only four have been established. The

reason again was a lack of funding; however, the result is that Washington State is not prepared to transition into the future of health care delivery. When the number of CBOCs in Washington State is compared with that of other states, Washington clearly lags behind in the establishment of this important community resource. For example:

STATE	VETERAN POPULATION	CBOC
Washington	670,628	4
Minnesota	446,864	23
New Mexico	187,006	13
Arizona	563,842	13
Colorado	437,515	11
Montana	106,060	10
Georgia	752,684	9
South Carolina	414,690	8
Alabama	435,831	7

The few CBOCs located in Washington play a significant role in the provision of primary care and the CARES Commission would do well to further study their placement in relation to the distances veterans must travel. If a CBOC is not the answer in a particular area, options such as contracted services or mobile clinics should be considered to meet the needs of the aging veteran population, especially in rural Washington.

Long Term/Nursing Home Care:

I would also like to address plans to contract for nursing home care in Vancouver and Walla Walla. WDVA undertook a Master Planning process to assess demand for long-term care in our State Veterans Homes. Projections for Washington are staggering. In the next 20 years, Washington veterans over the age of 65 will number 220,000. That's 20,000 more than today. The number of veterans over the age of 85 will triple—from 8,400 to 27,000.

The dramatic aging of our state's veteran population will lead to an increase in their medical requirements and will place significant demands on the VA Medical Centers, especially nursing homes. However, the lack of outreach and enrollment of veterans in Washington State has resulted in projections for long-term care that are artificially low.

As CARES reviews plans to contract long-term care out in both Walla Walla and Vancouver; the option of state / federal partnerships should be explored. Washington State and the National Association for State Directors of Veterans Affairs (NASDVA) have advocated for cooperative agreements between the VA and the State Veterans Homes in providing long-term care for veterans with 70% or greater disability. (See attached NASDVA Resolution.) Such state / federal partnerships would allow the VA to utilize another resource in the provision of care in facilities that are subject to VA surveys and have standards that are comparable or exceed those of VA nursing homes.

Contracting Mental Health Services:

In regard to the provision of mental health services at Vancouver and Walla Walla, I have significant concerns about whether the community is prepared to handle the demand and how

the VA will ensure that community contractors receive necessary training and oversight. Currently, there are no community inpatient psychiatric beds in Walla Walla and limited community beds in the Tri Cities and Yakima. The proposed realignment of mental health services in Walla Walla will result in no VA inpatient psychiatric beds in all of Eastern Washington. Such a change will call for significant training and recruitment efforts in both areas and their surrounding communities to ensure practitioners have the knowledge, skills and abilities to treat veterans with PTSD and other war-related trauma.

WDVA has established a comprehensive network of mental health providers and has been a critical player in providing services to veterans in their local communities through a statewide PTSD Network. The CARES process should take into consideration how a state / federal partnership could serve the mental health and transitional needs of veterans.

Waiting Times:

Any CARES plan that realigns or consolidates services within VISN 20 must also consider the subsequent effect on veteran waiting times. According to VISN 20 documentation, more than 65% of primary care appointments at Washington facilities – for existing patients – are made within 30 days. The same is not true for specialty services, especially in the state’s largest medical centers that lag behind the VISN 20, and are significantly behind the Veterans Health Administration averages. For example:

JUNE 2003 Data Puget Sound Health Care System Average	Veterans Health Administration Average
Next available <i>Cardiology</i> appointment 39.2 days.	VHA average is 27.2 days.
Wait times for next available <i>Orthopedics</i> appointments are double that of the VHA at 89.6 days.	VHA average is 44.3 days.
Wait times for next available <i>Urology</i> appointments are 30 days longer than VHA 65.2 days.	VHA average is 35.3 days.

Realignments within VISN 20 should focus on how some resources can be directed to areas with significantly high waiting times.

In addition, if consolidations or contracting are utilized in rural areas of the state, we must make every effort to ensure that waiting times for these veterans do not increase, but rather decrease as a result of the changes. We must maintain the high quality of services veterans are receiving, regardless of whether the care is provided by VA providers or through community contracts.

Realignment and Consolidation:

In regard to campus realignment and consolidation of services, I understand the need to evaluate and if necessary realign the missions of capital facilities. The Washington Department of Veterans Affairs with its three Veterans Homes and statewide Veterans Services

Network has undertaken similar initiatives to ensure our services meet the current and future demands of our veteran population.

However, reductions to the bricks and mortar of the VA must take into consideration how services will be provided elsewhere in the VA or in local communities. Collectively we must ensure that our veterans receive accessible, high quality primary, specialty and long term care services that are as good or better than those they receive today.

Summary:

CARES must re-examine the health care needs of veterans by not using arbitrarily low projections based solely on current enrollment. The CARES process must address the growth in Washington State's veteran population by aligning services to meet veterans' health care needs. Whether those services are provided in traditional VA settings, or through innovative partnerships, we must ensure that veterans receive care that is as good or better than the care they receive today.

We cannot afford to perpetuate the inequities of the past by relying on population projections based on outdated and inaccurate data. The reality is that the veteran population in Washington State has grown, those veterans are aging, and their demand for care will grow exponentially over the next several decades.

To serve the needs of our veterans, the VA must reach out and form partnerships with the many willing state and community providers. Additionally, VISN 20 must establish additional Community Based Outpatient Clinics to provide primary care services to veterans and eliminate the need for them to travel long distances and suffer long waits for routine care.

Finally, any restructuring of services must ensure the remaining resources are redirected to areas with the highest need, including reducing waiting times and increasing access to care.

Chairman Alvarez, your commission has the opportunity to ensure the veterans of Washington State are not forgotten. Your continued work with Dr. Les Burger, Veterans Integrated Service Network 20 Director and other veteran leaders in Washington State will determine how the needs of our state's veterans are met. I look forward to working more closely with you and other members of the CARES Commission and encourage you to contact me at 360-725-2151 should you have any comments or concerns.

Sincerely,

A handwritten signature in black ink that reads "John M. King". The signature is written in a cursive style with a large, stylized "J" and "K".

John M. King
Director

Geographic Distribution of VA Expenditures for Fiscal Year 2002
Summary of Expenditures by State

***Note: \$ in 000's

Note: RED information was inserted by WDVA based on VA Expenditure data on this table.

State	Estimated Total Veteran Population **	Veteran Population Ranking	Total Expenditures***	Per Capita Veteran Expenditures	Per Capita Vet Expend Ranking	Compensation and Pension***	Readjustment Benefits and Vocational Rehabilitation***	Insurance and Indemnities***	Construction and Related Costs***	Medical Services and Administrative Costs***
United States Totals	25,346,363		53,968,144	2,129		24,906,559	1,964,929	1,896,270	437,027	24,763,359
District of Columbia *	40,617	51	1,649,461	40,610	1	89,027	7,477	3,618	118,860	1,430,478
West Virginia	195,180	35	713,487	3,656	2	278,881	61,898	10,262	8,006	354,439
South Dakota	77,609	46	282,936	3,646	3	99,217	7,824	6,012	897	168,986
Arkansas	276,651	31	885,230	3,200	4	435,453	18,958	16,294	4,725	409,800
Mississippi	245,472	33	740,990	3,019	5	345,818	15,798	13,685	1,521	364,168
New Mexico	187,006	36	544,845	2,914	6	291,518	18,959	13,428	1,831	219,109
Alaska	68,050	47	195,617	2,875	7	94,783	6,849	2,550	107	91,328
Oklahoma	365,456	28	1,010,877	2,766	8	634,295	38,358	21,014	5,060	312,150
Vermont	60,405	48	166,269	2,753	9	58,912	13,847	4,374	25	89,111
Maine	148,137	39	393,418	2,656	10	241,548	12,785	9,751	5	129,329
North Dakota	59,058	49	152,110	2,576	11	60,752	5,499	4,912	3,272	77,674
Nebraska	167,500	37	424,437	2,534	12	197,851	14,464	13,799	2,586	195,737
Wyoming	57,236	50	144,797	2,530	13	51,447	3,810	3,639	302	85,599
Tennessee	549,713	17	1,361,323	2,476	14	611,309	37,449	28,194	17,928	666,443
Louisiana	379,358	25	936,692	2,469	15	465,057	29,147	22,604	2,286	417,599
Alabama	435,831	23	1,074,595	2,466	16	597,520	37,818	25,742	4,377	409,138
Missouri	570,987	14	1,391,725	2,437	17	494,092	36,643	36,548	13,616	810,827
Texas	1,701,118	3	4,102,078	2,411	18	2,146,882	162,999	107,434	32,805	1,651,959
Rhode Island	96,342	44	225,684	2,343	19	107,169	4,544	8,002	1,303	104,666
Colorado	437,515	22	1,003,183	2,293	20	426,399	48,341	30,292	3,165	494,986
Massachusetts	524,009	18	1,192,368	2,275	21	556,783	27,355	52,066	5,351	550,813
New York	1,253,731	4	2,826,236	2,254	22	1,050,404	95,335	126,931	11,610	1,541,956
Oregon	376,064	26	846,187	2,250	23	400,480	28,694	23,942	4,669	388,402
South Carolina	414,690	24	907,828	2,189	24	493,927	35,615	25,742	2,062	350,481
Kentucky	370,930	27	785,381	2,117	25	436,632	25,490	18,542	1,938	302,779
Hawaii	116,309	42	245,457	2,110	26	124,133	13,608	16,033	68	91,615
Kansas	257,452	32	538,361	2,091	27	226,374	18,099	18,854	5,712	269,322
North Carolina	779,393	9	1,623,060	2,082	28	933,050	75,318	46,260	4,851	563,582
Georgia	752,684	11	1,555,177	2,066	29	843,033	97,024	42,365	5,739	567,018

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County or Independent City										
Washington	649,046	12	1,339,283	2,063	30	770,113	64,501	41,878	1,203	461,588
Florida	1,846,327	2	3,760,631	2,037	31	1,901,396	140,012	174,773	22,832	1,521,618
Montana	106,060	43	215,816	2,035	32	123,221	7,730	7,621	173	77,071
Utah	159,321	38	323,665	2,032	33	129,146	12,075	11,802	352	170,291
Arizona	563,842	16	1,131,266	2,006	34	571,338	52,320	42,172	12,903	452,533
California	2,392,193	1	4,592,251	1,920	35	2,041,707	180,518	200,132	49,761	2,120,131
Minnesota	446,864	21	855,186	1,914	36	377,175	24,517	38,514	1,399	413,582
Nevada	241,248	34	453,531	1,880	37	216,227	14,344	13,142	391	209,428
Virginia	763,522	10	1,414,896	1,853	38	791,389	80,011	55,786	6,943	480,767
Ohio	1,086,352	6	2,011,724	1,852	39	792,249	54,786	71,545	10,990	1,082,154
Iowa	281,265	30	514,896	1,831	40	198,361	12,787	23,341	382	280,025
Delaware	82,188	45	150,435	1,830	41	65,051	4,064	5,831	727	74,762
Pennsylvania	1,209,970	5	2,161,189	1,786	42	948,493	51,497	99,472	14,101	1,047,626
Wisconsin	494,962	20	874,533	1,767	43	400,147	24,177	40,345	1,871	407,993
Idaho	136,792	40	239,857	1,753	44	139,733	10,730	8,114	180	81,100
Illinois	945,487	7	1,629,287	1,723	45	540,172	58,675	80,080	15,011	935,350
New Hampshire	133,232	41	227,424	1,707	46	137,834	9,748	9,903	63	69,876
Maryland	495,177	19	836,268	1,689	47	420,651	38,846	40,803	3,782	332,186
Connecticut	288,645	29	484,719	1,679	48	179,318	29,546	30,804	412	244,639
Michigan	865,321	8	1,214,244	1,403	49	543,882	36,190	52,026	17,899	564,247
New Jersey	628,493	13	862,485	1,372	50	448,331	29,913	66,653	9,438	308,151
Indiana	565,549	15	754,746	1,335	51	377,879	27,936	28,644	1,540	318,747

* District of Columbia totals include Central Office funding (included in the Medical Services & Administrative Costs category).

** Note: The veteran population data reflect estimated population as of September 30, 2002.