

WALLA WALLA

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**Statement by
 Sandra L. Kerr, RN, Chief Steward
 Representing the
 National Federation of Federal Employees Local 181
 Before the
 Department of Veteran Affairs Capital Asset Realignment for Enhanced Services
 Commission
 Regarding
 The VISN 20, Inland North Market Plan involving the Jonathan M. Wainwright VA
 Memorial Medical Center
 On September 29, 2003**

On behalf of the Professional Employees represented by the National Federation of Federal Employees I would like to thank you for holding this hearing in Walla Walla and providing us the opportunity to submit testimony.

As you are aware the recommendations presented in the National CARES Plan for VISN 20, Inland North Market, which includes the Jonathan M. Wainwright Memorial VA Medical Center states (Walla Walla) "Campus would no longer provide VA health care service, apart from outpatient clinics, and contract for services with community providers." Further noted is the statement "thus, the VISN's recommendation to close acute beds at Walla Walla was accepted." It is our interpretation that the *fate* of the veterans and the employees of JMWMVAMC has already been determined (Appendix F – National CARES Plan, page 10).

The plan also "proposed consideration of relocation of nursing home services to a more populous area and/or contracting." The plan is unclear if this is the final recommendation or if it remains under review for realignment as suggested in Chapter 19, Extended Care Improvements, New Construction. As we look at these decisions one has to consider the impact it will have on the new Palliative Care and Hospice initiatives. At present not enough funding has been provided for these end-of-life care services, however, moneys have been directed to JMWMVAMC for refurbishment of rooms to meet the need for Inpatient Hospice/Palliative Care with allocation of that funding to be completed by this week. If contracting long term care patients cannot be done locally, a hardship of separation and support for patients and families will be created.

There is concern that in contracting services, while possibly increasing access to hospital services, it may negatively impact the degree to which the care for our veterans is coordinated over time, among multiple practitioners and other VA facilities. Currently veterans receiving care within VA facilities benefit from the ability to coordinate both inpatient and outpatient care utilizing the Computerized Patient Record System and it's ability to share health care information among all clinical staff. How healthcare information will be shared across different organizations with different systems of records and ensure the same continuity of care is unclear.

There is no question that a plan to address our campus infrastructure needs and strategies to improve hospital access for veterans within our market area is needed. From past history, veterans from our facility often receive less than timely services from our tertiary facilities who are already feeling “overwhelmed.”

There is concern that implementation of these recommendations without additional review of market capacity, particularly for inpatient psychiatric services, and without assurances of sufficient funding for contracted services may result in an unintended decline in services. It is hoped that the CARES Commission review of the Under Secretary’s plan will recommend the plan include an increased emphasis on the need for assurances that access to hospital, psychiatric and nursing home services for our nation’s veterans can be met in this market area and that sufficient funding is appropriated before implementation planning proceeds. Additional concerns include the reduction of care/services to NSC veterans and a system geared to treat only those who are SC. Please remember that we again are a nation “at war” with service men and women and casualties returning to DOD programs that have reduced their number of tertiary facilities with the intent of utilizing the VA tertiary facilities to meet influx of new veteran populace.

There is concern that veterans receiving care in contracted inpatient facilities also may not benefit from other such systems in place in VA facilities such as Bar Code Medication Administration, which was designed to enhance patient safety by reducing medication error.

One should keep in mind the unique culture of rural Eastern Washington, Eastern Oregon and Idaho. Veterans coming from this area have chosen to reside within communities that foster peaceful, serene, family and friendly atmosphere. The JMWMVAMC has for many years provided a safe haven in which their medical needs can be met. One veteran described his WWVAMC experience as stepping into a *Norman Rockwell* painting where everyone knows each other’s names and demonstrates care and compassion as supportive family members. Expecting these veterans to navigate their way to/from and through large metropolitan VA Medical Centers and/or private Healthcare Organizations unfamiliar with the veterans’ unique needs would be extremely difficult, if not impossible.

The veterans served at JMWMVAMC have chosen often times to manage their PTSD symptoms by living isolated lives. For these veterans “trust” is hard to come by. The JMWMVAMC may be the veteran’s only true connection with the outside world.

Despite the condition of our buildings, the difficulties in remodeling them and maintaining them to make them safe, the annual budgetary struggles and the repeated speculation about mission changes over the years, we do a good job here. The plan points this out. It notes that we were the recipients of the Carey Award for Quality, one VA’s highest awards. It notes that small facilities consistently score well in patient satisfaction surveys and we do. It reflects that our JCAHO accreditation scores are in the top percentile.

We do a good job here because of the skill and dedication of all of our employees. I hope that your review also recognizes this and ensures that our nation's veterans continue to benefit from their services.

Although it may be possible to address these concerns prior to implementation of the proposal to contract out inpatient services it is hoped that the CARES Commission will include specific recommendations to ensure that coordination of care is not adversely impacted and that comparable patient safety processes and systems are in place so that veterans receiving care are not disadvantaged in any way.

VA services/budget constraints have traditionally been influence by the tone of those in Congress. Today's Congress contains many members without military service in time of war or peace. We have "re-invented the government, do more with less" and watched the services available to veterans dwindle.

In conclusion, closure of this VA's inpatient services would be the same as extinguishing *the lighthouse beacon of hope* these veterans have embraced.

Thank You,



Sandra L. Kerr

**Written testimony by Ed Terry, AFGE President
Local 181, Walla Walla, WA**

**Submitted to the Cares Commission for
consideration of the Hearing to be held at
Walla Walla
On September 29, 2003**

We would like to thank the Commission for this opportunity for us to provide input to the Cares plan.

As employee representatives, we feel our responsibilities are twofold. These responsibilities are to represent the employees of our bargaining unit, and to work with management to provide quality health care for our veterans. These two responsibilities go hand in hand, and are especially meaningful for those employees that are also veterans seeking health care from the VA.

These two unions represent the majority of employees that will be most effected by the changes that have been proposed. American Federation of Government Employees/AFGE, Local 181, has a non-professional bargaining unit of 168 employees, which 72 are dues paying members. Of the approximately 360 employees employed at Walla Walla, 107 of these employees are veterans.

This facility has a long history of providing opportunities for returning veterans, whether it be offering direct hire employment opportunities, or by offering job enhancement skills through programs such as Compensated Work Therapy, Incentive Work Therapies, temporary positions, or summer work studies. Many worked part-time while going to school. Many of our employees grew up in the surrounding area and left to serve their country and returned to go to work here at the VA.

In 1993 the Walla Walla facility had a cumulative FTEE of 344.1 with a medical care expenditures of 21.3 million dollars. In 2003, we have a cumulative FTEE 327.8 with expenditures of 37 million. Every year we increase the number of veterans that we care for with fewer employees. As the cost of health care increases it is the employees that are asked to increase their workload with fewer employees to do the work. Now it is going to be the employees that are going to be impacted again.

Our employees exemplify the motto: "putting veterans first". There are many employees that have made their careers at Walla Walla. Many have bypassed opportunities of advancement and higher pay in order to stay in Walla Walla. We do so because we believe in our mission and we believe in our purpose to provide quality health care to the veterans in this area. We know many of the veterans by name. To many veterans, we are like family, and to some, we are family.

As an example, this last year we lost a brother. He devoted his career to serving his fellow veterans. His job was at a lower wage grade, but to him, it was a career to which he literally gave his life. He was a front line worker and always had time to help a fellow veteran. We lost him to cancer complications from agent orange exposure.

Should the mission of the Walla Walla Veterans Hospital be changed to an outpatient clinic, many of the employees that we represent will no longer be needed. Those employees directly effected would most likely be our food service, laundry, maintenance and repair, and building management personnel. We have been told that there would not be a reduction in force and that the work force would be reduced through normal attrition. This normal attrition might include "take it or leave it" offers to transfer to other facilities not necessarily in this area. This would mean moving employees who grew up here and may have lived here their entire lives, except for military time. The impact could be separating families and secondary families, in order to continue their federal careers.

We know there is a need to provide a continuity of care at a quality as high or higher than that provided in metropolitan areas. There has been an ongoing paranoia among employees and veterans that whenever there is talk of saving money or changing missions, Walla Walla is the first to be mentioned. In the mid 80's, the regional director attempted a wholesale change to an outpatient clinic. In 1987, Congressman Tom Foley blocked our mission change through legislation. Our surgery suite and surgery ward have since been closed. Our nursing home patients have been moved and combined with the inpatient medical wards.

During the past 25 years, minimal construction dollars have been allocated, to this facility, as a patchwork, rather than needed new construction. The employee perception is that Walla Walla was not treated as fairly as other facilities in the network, when it came to funding new structures. History shows no major construction projects done at this facility. The last projects classified as minor construction were in the early 1980's. (Attachment C) This added to the paranoia that funding for new construction at Walla Walla was not a VISN priority; Walla Walla was either not considered as important as the bigger facilities or eventually would be closed or be changed to an outpatient facility some time in the future.

Now, CARES has asked the VISN to make a recommendation as to what to do with these old buildings and what to do with the veterans that we have been providing health care. The recommendation was not to come up with a solution to continue providing the same quality of care or continuity of care, but to put the work out into the local community.

We have always been told that the VA provides unique care to the veteran that cannot be found in any other health care system. This unique care includes agent orange, Gulf War Syndrome, PTSD, etc. This seems contrary to the proposal to contract out our inpatient beds. Is this compatible with quality care and continuity of care? Records show that Walla Walla has continually scored among the tops in the nation for quality of care and customer service. Sending these veterans to other facilities or contracting them out disrupts the model of providing continuity of care. This facility uses care guide lines which gives exemplary care to our veterans.

The proposed plan to close the inpatient mental health capabilities at this facility is based on the perception that inpatient success rate is no better than in an outpatient setting. The criteria that is used to assess these patients deems that their therapy be done in an inpatient setting, where we have a very high success rate, and cannot be accomplished in an outpatient setting. The fact that we have 5 different bed specialties in our unit, feeds to the success rate of our program. We receive many veterans for our inpatient program from other facilities because they know our inpatient program will be more affective than in their own outpatient capabilities. 41% of our SAARTP patients come from outside our service area.

The other issue of contracting out of the acute beds, in mental health, leads to other problems. We have experienced that there are no private facilities close to our area that provides acute psych care. Having acute psych beds allows continuation of care for those patients until they can be moved into one of the program beds keeping the continuity of care intact.

Veterans in rural areas have the same rights to good health care as veterans in metropolitan areas. Population density should not determine the quality of care.

Veterans in the rural area, this rural area in particular, should have the same quality of care as in the big city. And this facility has provided that quality care to the veterans in this area.

The Cares plan has identified that it would take 7 million to update building 86, and 5 million to update building 69. This would amount to one third of one years medical care budget. Why not update these buildings and continue the quality care that the veterans here are used to, and deserve? And let us continue to do what we do best.

We are not opposed to the CARES process and what it's trying to accomplish. We agree that VHA needs to plan for the future needs of our veterans. Our main concern is that actions on these proposals would be premature. The CARES planners determined, in mid-year, that the IBM software used previously for private sector facilities did not have categories for accumulation of data on various VHA programs or services. These excluded services are long-term care, domiciliary care and outpatient mental health care (including SAARTP beds). The CARES planners made the decision to hold off on the previously mentioned services until the next phase. Without reliable data, long-range plans would be premature at this time. (Attachments A & B)

The Draft National CARES Plan fails to address the expected demand for veterans' long-term and extended care needs. We urge the Commission to correct this glaring defect in the objectivity and sufficiency of the Draft National CARES Plan. How can the Commission confidentially recommend that the proposed Draft National CARES Plan meets the demand for veterans' health care services over the next 20 years if it does not fully address the long-term and extended-care needs of elderly veterans?

Another issue we want to bring to the commissioners attention is the potential change in revenue to this facility. Should we become strictly an outpatient facility, we would no longer be able to bill as a hospital. Currently, we assess a "facility fee" for

outpatient visits. If we were to loose our classification as a hospital and became a clinic, then we would loose the ability to bill the "facility fee". This could be a considerable loss of revenue to us. (Attachment D)

ATTACHMENT A

Qs & As – Under Secretary’s Review of CARES

Why has the timeline of events for CARES been altered?

Over the course of his review of Network market plans, the Under Secretary for health concluded that it would take longer than expected to produce a comprehensive national review of the proposed VISN CARES plans. After being briefed by the Under Secretary, Secretary Principi provided the following guidance, “it is clear to me that the current CARES timetable does not allot sufficient time for the national-level review and adjustments you must make to the VISN plans before they are passed on to the CARES Commission for their review. I recognize that I insisted on a very tight schedule for every point in the process. But after evaluating our progress, I believe it is more important that your recommendations to me be informed by your assessment of opportunities ... rather than rigid adherence to the schedule.”

What is the practical effect of this change in the CARES timeline?

It will delay the beginning of about 40 hearings across the country by our CARES commission from four to six weeks. Instead of beginning at the end of June, the hearings will begin in mid-August. Also delayed will be the Secretary's final decision on the recommendations presented to him by the CARES commission. His decision, originally scheduled for late November, will now take place in late December.

Is there a list of facilities scheduled for closure?

No, there is no “closure list.” The Under Secretary of health did ask a number of networks to develop or consider additional options in their market plans that would consolidate a number of two-division facilities into a single inpatient campus. In each of these cases, the networks were to develop options taking care to preserve current bed levels for nursing home and inpatient long-term mental health programs. Dr. Roswell also asked certain networks to develop new options that would convert several smaller inpatient facilities to outpatient care facilities. In other words, he asked networks to look at strategies to convert from a 24-hour operation to an 8-hour a day operation. These new options were sent to headquarters June 13 and are being evaluated.

Which facilities were asked to provide more information?

| VISN | Facility Name: | Nearby Facility |
|------|--|--|
| 1 | Bedford | Brockton |
| 2 | Batavia | Buffalo and/or Canandaigua |
| 3 | Lyons | VA New Jersey Health Care System |
| 3 | St. Albans | Brooklyn |
| 4 | Pittsburgh (Highland Drive) | Pittsburgh (University Drive) |
| 7 | Augusta (Uptown Division) | Augusta (Downtown Division) and/or Eisenhower |
| 7 | Central Alabama Veterans Health Care System (CAVHCS) | |

| | | |
|----|---|------------------------|
| | | East and West Campuses |
| 8 | Lake City | Gainesville |
| 9 | Lexington (CD or L) | Lexington (CD or L) |
| | Cooper Drive Division and Leestown Division | |
| 10 | Brecksville | Wade Park |
| 11 | Marion | Ft. Wayne |
| 15 | Leavenworth | Topeka or Kansas City |
| 16 | Gulfport | Biloxi |
| 17 | Marlin/Waco | Temple |
| 17 | Kerrville | San Antonio |
| 20 | Vancouver | Portland |

Please note: Dr. Robert Roswell, Under Secretary for Health, has concurred with the VISN 20 recommendation to retain both the Vancouver campus of VAMC Portland and the services provided on that campus.

| | | |
|----|-------------|------------|
| 21 | Livermore | Palo Alto |
| 23 | Knoxville | Des Moines |
| 23 | Hot Springs | Ft. Meade |

What will the Under Secretary do with this information?

Dr. Roswell will review the draft Market Plans and the newly requested information to complete his review and present a Draft National CARES Plan to the Secretary.

The Under Secretary's review was built into the CARES planning process as a deliberate step to assure a national perspective and produce a consistent, systematic plan, a sharing of best practices and good solutions, and equity and balance in the final report. The CARES program office, national veteran service organizations, DoD representatives, teams made up of headquarter and field employees and a special Clinical Work Group are all assisting Dr. Roswell in his review.

What about Stakeholder input?

The Under Secretary's review of the draft Network Market Plans is still an interim step of the CARES process. After his review, he will submit the draft National CARES Plan to the Secretary, who will in turn, present the draft National Plan to the CARES Commission. During the three-months of Commission review and hearings, veterans and other stakeholders will have ample opportunity to comment on the plan, before it is presented to the Secretary for final decision in December. The step of consolidating local information and plans into a cohesive national product is an important one, and veterans and stakeholders will be encouraged to comment on the draft National Plan.

Is there a goal for the number of beds VA hopes to close as a result of CARES?

No. There are no goals for overall bed closures. The goal of CARES is to develop a plan for the best national program to serve veterans for the future.

What happens to the money saved from consolidations?

Any savings from consolidations will be retained within the network to expand and improve services for local veterans.

Long term care is not included in CARES, why and how will VA plan for the future without considering such important medical care?

Changing health care delivery will almost certainly impact future demand for a variety of non-institutional services. As such, long-term care, domiciliary care, and outpatient mental health care were all determined to need more work before forecasting models and reliable forecasts could be made.

Although not comprehensively addressed in the draft CARES National Plan, VA is committed to refining these levels of care in the near term and incorporating them into the strategic planning process. Current bed levels in long-term care and treatment capacity in these programs will remain constant until this strategic planning process is complete. The Department began CARES with an understanding that its complexity demands a focus on continuous improvement through study and experience. The strategic planning process will help assure attainment of this goal.

Why is VA considering the shift of inpatient beds from some large hospitals when we might need these facilities for long-term care in the future?

In the event that additional long-term care beds are needed, converting an old hospital into a modern long-term care facility will cost substantially more than building a new facility dedicated to long-term care. Even then, converted older hospitals can't match the quality of a facility custom-built for long-term care.

Maintaining duplicative or obsolete facilities as contingencies for possible future use would consume resources needed to care for veterans today. Resources are needed today to expand the non-institutional long-term care VA plans to offer more veterans. We know that many veterans do not want to go into long-term care facilities, where they are removed from family and communities and, typically, forced to live apart from a spouse of many decades. It is VA's goal to be a leader within the health industry, exploring innovative ways to keep people in their homes through tele-health programs, visiting nurses, adult day care, home health aides and other services

Some lawmakers have criticized VA for reducing the number of long-term beds under CARES. What is VA's reaction?

No one currently receiving VA long-term care will lose that care as a result of CARES. VA central office has directed local and regional managers to preserve their communities' capacity for long-term care throughout the CARES process. Their guidance was to stay within the Millennium Bill requirements.

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**MEMORANDUM FOR THE RECORD
VSO CARES Briefings
Executive Directors**

March 25-26, 2003

Disabled American Veterans
The American Legion
Veterans of Foreign Wars

Executive Summary

National CARES Program Office Executive Director Smith Jenkins briefed the Executive Directors of the Disabled American Veterans (DAV), The American Legion (TAL) and the Veterans of Foreign Wars (VFW) in their Washington Offices. Mr. Jenkins briefed on the CARES program to date and sought to elicit their concerns and comments about the program. The meetings also sought to encourage a discussion of the VA communications efforts and future needs for the success of the program.

The initial meeting was held on March 25 in the offices of the DAV. Dave Gorman, DAV executive director, Joy Ilem and Joe Violante of the legislative shop attended. On the 26th, both the Legion and the VFW were briefed. At the TAL, Executive Director John Sommer, was joined by Steve Robertson, Peter Gaytan, Carol Rutherford, and Kathy Wiblemo. At the VFW, Bill Bradshaw joined Executive Director Bob Wallace.

Status

All three organizations are well versed in the program and the progress to date. The VFW said that they "embraced CARES as a way to mold the future" of VA health care. Each organization appreciated the decision to be sent the market plans as soon as they become available after April 15 from the field.

Communications

All three organizations agreed that, for the most part, VA communication efforts on CARES in Washington were very good, timely and responsive. The TAL and VFW noted however that there were various communication issues in the field. These were two-fold. One is that some of the veteran field representatives were not as familiar with the data and the project as their colleagues in Washington, making it harder for them to have significant input at the local level. The second point was that the field representatives universally say that more time is needed to review the "complex" plans and form recommendations in so short a timeframe. Both organizations identified certain VISNs as lacking a full outreach and communication plan. The VFW expressed some concern as to how the communication reports were generated, as they thought that some of the statistical elements of communication seemed over-blown. The VFW allowed that their concern stemmed from what they perceived to be a complete communications mismanagement in Phase I in Chicago. They were willing to give VA another "chance" in Phase II, but warned that VA better do it right.

The CARES Model

All three organizations seemed satisfied with the CARES model. The one serious exception expressed was that certain specialty care concerns were not brought into the process yet, notably long-term care and mental health. Mr. Jenkins noted that current work on these issues will allow their introduction into the strategic planning cycle very soon, and will include

women's issues. John Sommer at TAL asked whether those category 8's with 3rd party insurance were identified within the context of producing data from the model, and was assured they were captured.

Concerns

At the national level, each of the three organizations stressed concerns about specialty care within the CARES planning process. The VFW was concerned as to how the CARES Commission could possibly deal with the long-term care (LTC) issue when NCPO is not making it a part of their planning process. They were also concerned that none of the Planning Initiatives involve any LTC planning. Mr. Jenkins stressed that there would be a committee this summer comprised to deal specifically with LTC recommendations for the CARES process. Enhanced Use lease authority was discussed in each of the venues and it was agreed that the process is important to CARES and should be reviewed here at VACO for full effectiveness.

Dave Gorman spoke about the process following the SecVA final sign-off on the CARES plan, and how it is then presented to Congress. His question was whether VA had a "Plan B" should the original plan fail to muster support in Congress. The DAV and TAL each asked how the VA's 4th Mission was addressed within the CARES process.

Dave Gorman asked whether VA's Vet Centers were involved in the CARES process (No).

CARES Commission

Brief discussion of Commission and their visit to S/HVAC on March 25th discussion g various issues such as briefings and timetable. It is expected that the VSOs will soon address the CARES Commission and will gain a fuller understanding of the Commission then.

Danny Devine
OCLA
March 26, 2003

ATTACHMENT C

In 1981, there was a seismic correction to building 86(which is the current location of our inpatient medical and nursing home) and the project to modernize our primary and secondary electrical systems. We might add that building 86(built in 1930's) is the building that received a cares overall space score of 1.88, and is the only building to have seismic corrections on site, and still does not meet modern seismic corrections.

Completed in 1995 were two miscellaneous projects of \$750,000 each. These added the pharmacy and additional exam rooms to ambulatory care building 74.

Non- recurring maintenance of \$1.2 million was spent for the access road and canopies for the front and back of the ambulatory care building.

In recent years, there has been several small projects approaching one million dollars remodeling the multi-care unit, to accommodate the decision to combine the nursing home care beds with the acute inpatient beds on the same ward.

In progress now is a project in the laboratory for another \$1 million.

The only other project of any size was a remodel of the Mental Health ward for \$390,000.

**CARES PROPOSAL
JONATHAN M. WAINWRIGHT MEMORIAL
VA MEDICAL CENTER
September 11, 2003**

The proposed plan to change the mission of this facility from a hospital to an outpatient facility will greatly impact the revenue charged and collected from our insurance carriers. Currently, we have a hospital based outpatient clinic that allows billing for "facility fees" for each appointment.

EXAMPLE – utilizing data from FY 03 (October 1, 2002 – present)

4474 Insurance billable visits
80% Billable Technical (facility) charge
3579 Visits Chargeable for Technical fee
@\$163.01 (facility fee – basic)

\$583,445 Revenue Loss

All revenue collected is retained by the facility as part of its budget toward patient care.

This change in mission will be devastating to this facility.

Please take this into consideration when making your decision to close our Hospital status.

Thank you.

Sherri L. LaCross
Revenue Coordinator
Business Support Service

WALLA WALLA



The following panel members represent
AMERICAN FEDERATION OF GOVERNMENT EMPLOYEES

Ed Terry, President, Local 181, Walla Walla, WA
Tony Gilchrist, President, Local 1108, Spokane, WA
Keith Himel, President, Local 498, American Lake, WA

In an attempt to put our thoughts into a language that everyone would understand, we planned to title each major point with a catchy acronym. It didn't take us long to figure out these skills are not at our level. We decided to speak from the heart. A universal language.

Rather than using terms like access and demographics, we intend to speak of the impact on our extended family. We hope to show you that quality can be achieved in more than one way.

Yes, we are a family! Yes, at times we'll admit we come close to being a dysfunctional family. After all, in the twenty years I've been here, we've had five and a half different heads of household. The point we want to convey to the commission is this; we do function as a family. Rural health care is different. Our veterans look at this place as "home" and to some we're the only home they have. One example is our mill bill patients. Just last Thursday, Sept 25th, our local newspaper had an article about the passing of Grandpa Frank. Frank was a WW11 POW and always vocal about his war years. Friday several employees approached me that were obviously going through various stages of the grieving process. Years ago when my son was the victim of a homicide, my co-workers and fellow veterans helped me through that same grieving process.

Our point is, "Rural Health Care" is not the same as a large urban medical center. Through years of ongoing training our employees are multi-skilled. The Henry Ford assembly line does not work here.

There is the perception that since we're small, quality suffers. Numbers don't tell the story. Results are what should count. About a week ago we had a strategic planning retreat. I was amazed! Little old Walla Walla repeatedly is second in the nation, or third in the nation, or tops in the VISN in several categories. And yet we hear that quality suffers because we're small?!!!

To shut down services due to size is the old cookie cutter approach. In the VA, our cookies are not all the same size. Once again we want to emphasize, Rural Heath Care is not the same as in the metropolitan areas. We cover a vast geographical area.

Once again we want to express our thanks for you folks coming to see us! Those of you that were here for the "walk through" learned that the trip from Walla Walla to Spokane is a whole lot more than an inch on the map. Your drive up here from Portland, even though quite scenic, is a long stretch for an elderly vet. Seattle is even longer, and more hectic. Sending our Vets and their families to these other VA's is not a real option.

There is talk of contracting out some of our services. At what cost to the veteran? We're not talking about financial cost but what is our veteran going to lose? We provide a unique care, that the private sector is not capable of even coming close to. Through years of experience in treating these unique needs, we function at a level that private care will never achieve. Our vets deserve the best and that's us!

Believe me, we understand the tight dollar. Sometimes we feel short staffed, but we manage to get the job done. We've watched our facility deteriorate a little at a time, and yet we grow in other ways. The flowerbeds and manicured lawns of twenty years ago are gone, but we manage to focus on what counts. We are here to serve the veterans!

We the employees are thankful to see the CARES process. We hope, and yes, we pray, that it's not another political agenda to privatize, but is truly an effort to economize. When we look at Walla Walla being only 4.8% of the VISN operating budget and around 4% of VISN Non-Recurring Maintenance dollars, we think it's time to invest in our effort, not cut our opportunity to serve. We've watched new buildings go up at most other facilities and we continue to patch up these. We believe the cares plan is on the right track when it consolidates large medical centers in metropolitan areas where the big dollars are spent, and where they don't have the geographical challenge rural operation have. We agree that our structures need help, or in some cases need replacement. With the revenue saved in metropolitan areas it may be possible to provide facilities to rural areas which will facilitate the quality of care our rural veterans are receiving.

Before taking such a drastic step as cutting our services by moving them to another facility or contracting out, we ask that the commission and secretary take a good look at the care process. It's no secret that there were growth pains this year. Adapting the software to unique VA services in the areas of Mental Health and Long Term Care presented a lot of challenges. As always, these challenges will be met. However, this may not be the time to

disect our continuity of care in Walla Walla. PLEASE LOOK AT THE WHOLE PICTURE.

We feel an important step is being overlooked. The healthcare providers should be asked to provide their assessment on what the impact on veteran care will be, should the CARES Initiatives be implemented. Nowhere have we seen that this input by physicians, social workers, psychiatrists, or any other health care provider has been documented.

Our mental health folks tell me their inpatient beds provide many different types of care and their outpatient rehab program, which provides beds and meals, draws patients from Alaska and Montana as well as our catchment area. Our homeless vet program is a benchmark operation with its many programs. All of these mold together to provide continuity and unique veteran care. Also, it should be noted that there are NO private mental health beds available in Walla Walla, Tri-Cities, or Yakima, so contracting out our mental health in-patient beds is not a real option.

The medical unit we call our nursing home is also more complex than the title "nursing home" conveys. Our multi skilled caregivers combine a walk-in clinic, rehab therapy, an acute care unit, various stages of long term care, (including mill bill), and truly lives up to the name Multi-Care Unit.

To attempt using other sources of care for the mental health program or nursing home at this time without thorough and accurate data would be devastating to veteran care in this rural area!