

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

Third Meeting
April 2-4, 2003
Crystal City, Virginia.

Meeting Report

Commissioners in Attendance:

Everett Alvarez, Jr., Chairman
Charles Battaglia
Joseph E. Binard
Raymond Boland
Chad Colley
Vernice Ferguson
John Kendall
Richard McCormick
Richard Pell, Jr.
Robert A. Ray
Raymond John Vogel, Vice Chairman
Jo Ann Webb
Michael K. Wyrick
Al Zamberlan
Richard Larson, Executive Director

Wednesday, April 2, 2003

Chairman Alvarez opened the meeting with a moment of silence in honor of the U.S. service Commissioners who have died in the Iraqi conflict.

The Chairman reviewed the agenda for the day, which includes the National CARES Program Office's (NCPO) last presentation on the CARES model, lunch with the Secretary, a status report of the model by outside experts and presentations by stakeholders.

**Presentation By
Jill Powers, Deputy Director
National CARES Program Office**

Ms. Power's presentation focused on the process and planning tools being used by the VISNs to resolve Planning Initiatives (PIs) at the local level. She stressed the amount of planning off-line done by the Networks to get to the point where they could use the tools.

Resolving the PIs is part of Step 4 (Develop Market Plans) of the CARES Phase II process.

Resolving Planning Initiatives

In resolving the PIs, NCPO provided VISNs with a list of general alternatives they were required to consider. Final recommendations are to show what else was considered and why the recommended alternative was selected. Alternatives were specified for each of the CARES categories: access, proximity, small facilities, workload capacity and vacant space.

For Access PIs, related to improving *access* to primary, acute, and tertiary care, VISNs used a "map point" tool to identify under-served counties. The "access application" tool is used to recalculate enrollment by geographic area resulting in changes to improve services (adding or removing facilities, for example). A database of VA enrollees by zip code is used. When access is recalculated for each market, changes made by the Networks are seen by geographic area for the years 2012 and 2022. Asked how the tool is being used, Ms. Powers explained that VISNs use the tool to look at county data to see which counties aren't being adequately served. They can then place new services in an area and see what the effect will be on the under-served population. In response to a question about how the VISN can compute what will happen if it doesn't know what a new clinic will offer, Ms. Powers said the VISNs are only concerned at this stage with whether access is available somewhere within 60 minutes driving time. She said the population database includes both enrolled veterans and total veteran population.

The next step is to select where the care for the projected enrollees should be located. VISNs must examine several alternatives: community contracts, sharing (with DoD or with VA affiliates), leasing a new site, constructing a new facility and expanding services at the existing site, and formal consideration must be given for two of the alternatives.

For Proximity PIs, VISNs identify potential efficiencies and quality improvements. There are different requirements for acute care facilities and tertiary care facilities. For acute care facilities, the required alternatives are: (1) the status quo (no additional consolidations), (2) maintaining only one of two facilities, and (3) consolidating or integrating existing facilities. For the resolution of Tertiary care PIs, VISNs are required to consider two alternatives: consolidating and integrating facilities plus one other option of their choosing.

For Small Facility PIs, the goal is to assure appropriate quality in a cost-effective manner. VISNs must consider four options: (1) retain acute beds; (2) close acute beds and refer patients to another VA medical center; (3) close acute beds and implement contracting, sharing or a joint venture; and (4) a combination of 1-3 or other VISN options.

Asked what would have become of Iron Mountain VA Medical Center, a VISN 12 small facility, under this criteria, Ms. Powers said its retention would probably have been justified but it would have had to go through the process. A Commissioner suggested

that the Commission would run into this kind of situation with small facilities when it holds field hearings. There are about 20 small facilities identified as PIs. Some of the decisions will be highly scientific; others will not be.

Ms. Powers was also asked what options a Network would have to consider if there were two tertiary facilities close to each other -- would they be asked to combine even if the move would create political issues? She replied that tertiary facilities already have a huge capacity; combining two would exacerbate the situation, so it probably wouldn't happen.

Workload Capacity PIs involves meeting changing demand and identifying efficiencies and quality improvements. VISNs are analyzing different alternatives depending on their situation. In markets where workload capacity is increasing, VISNs must consider two of the following four alternatives: (1) manage the increasing workload in-house, (2) manage the workload by contracting out, (3) manage the workload through arrangements such as sharing or joint ventures, and (4) establish a new site of care. In markets where workload capacity is decreasing, VISNs must consider three options: (1) consolidating space, (2) redirect staff and resources, and (3) steps to lessen the impact on support services.

Ms. Powers said the Department of Veteran Affairs' goal is to reduce vacant space by 10 percent in 2004 and by 30 percent in 2005. PIs for *Vacant Space* require the VISNs to consider two of the following: (1) out-leasing, (2) divesting, (3) demolishing, (4) enhancing use, and (5) donating.

Asked about the difference between "out-leasing" and "enhanced use," Ms. Powers said that out-leasing involves renting the space for a purpose other than providing VA services, such as a golf course. Enhanced use involves leasing some or all of the space to a health organization, such as the local Red Cross, who would improve it before using it.

The *criteria* applied by the VISNs to analyze the alternatives for their market plans are:

- health care quality and need;
- quality of service as measured by access;
- safety and environment;
- impact on research and academic affairs;
- impact on staffing and the community;
- support for other missions; and
- optimizing the use of resources.

In response to a question about whether the Networks are taking the above criteria seriously, Ms. Powers said it is likely that different hospitals are using them differently and that some criteria, such as safety and environment and the impact on research and academic affairs, are being taken more seriously than others. Overall, however, she believes that the criteria are being taken seriously because the VISNs don't want their PIs to be sent back or to lose their chance for capital funding.

Market Planning Template

Ms. Powers next explained the web-based Market Planning Template that IBM developed. The VISNs are inserting their Market Plans into this template over the internet. The template ensures a standardized process for all VISNs by requiring them to use the data that headquarters supplies for:

- Workload demand,
- Space, and
- Costs (both operating costs and capital costs).

Once this data has been loaded into the system, VISNs can ask for changes only in cost and profit data. When the template is used, VISNs have accepted the data given to them.

The template uses a very linear process that starts with (1) the *facility inventory list* -- where the care is to be provided. Using the tools provided, VISNs then (2) calculate *access* to the facility, (3) select a *CARES category* then (4) *allocate demand workload to the treating facilities*. Workload data is static (*i.e.*, "fixed" -- VISNs can only redistribute it to new facilities and they cannot touch workload that crosses VISN lines unless a new start facility is added on the geographic border and the workload allocation is worked out with the other VISN). This step represents the real work involved in preparing the market plan. Once workload has been allocated to a treating facility, the VISN (5) decides how to *manage the workload* at that facility -- in-house, contract, sharing, etc. The next step (6) is to *manage space* at the treating facility based on what kind of space the facility needs. After that, the template (7) *calculates the cost* of the space using standard factors. The final steps are to (8) *evaluate the alternatives* and (9) *select the best alternative*. The VISNs then start the process over again using the selected alternative for each CARES category.

Q&A/Discussion

The Commission questioned Ms. Powers about the use of static demand in the model, noting that there may be unmet demand that could change the picture. Ms. Powers replied that while demand is not based on current need, it is based on where enrollees go for care now. If a VISN makes a change in a facility, it is necessary to move the demand to or from somewhere. All demand has to be accounted for and the VISNs are only allowed to redistribute that demand -- they can't create new projected demand to justify a facility.

A Commissioner emphasized that the Commission is not comfortable with how the CARES process accounts for unmet demand and said it will be a big issue for the Commission. In reply, Dr. Berkowitz emphasized that demand in the model is not based on current VA utilization projections; it is based on private sector demand applied to projected enrollment. He said that some of the Commission concerns about the model are valid and that he would be addressing those later. He said that facilities look at current utilization in trying to decide what portion of the projected demand will go to facility "A" and what portion will go to facility "B." This only shows them where the

enrollees are going --the projections are not based on current utilization. The Milliman demand data is the starting point for the template; VISNs can't change those numbers.

Demonstration of IBM Template

Ms. Powers next provided an on-line demonstration of the IBM template, noting that the VISNs are now engaged in using it to enter data for their market plans.

She went through the steps noted above using the New York City/New Jersey VISN (VISN 5) and the Texas VISN (VISN 17) as examples to highlight the prominent features of the template. Ms. Powers showed some of the forms included in the template, pointing out what information is supplied to the VISNs (the "fixed" information or "givens" that can't be changed) and indicating what information the VISNs are required to enter. The template provides baseline workload by CARES category for each market and projections and gaps through 2012 and 2022. The template also shows where people went for care during the last five years as a "default" allocation; VISNs are expected to reallocate the workload by treating facility as part of analyzing alternatives. Ms. Powers showed several examples of ways in which the workload could be allocated and also demonstrated some of the limits imposed on the process (primarily those that would allocate workload across Network geographic boundaries). Once the workload has been reallocated, the VISNs look at options for managing the space. Again, Ms. Powers demonstrated the options and tools that are available to the VISNs for considering management alternatives. She also demonstrated the functional scorecard tool that is included in the template that shows how well the space would be managed under the different alternatives being considered. A final outcome table shows what alternatives were considered and compares workload numbers by CARES categories to aid in decision making. Once this process is finished, the Network planners use the results as the basis for repeating the process for the next CARES category.

Q&A/Discussion

A Commissioner asked whether Central Office guidance specifies that workload reallocations should bear a reasonable resemblance to where people live. Ms. Powers replied affirmatively, indicating that the template won't let the Networks do some things, such as reallocate workload to a small facility.

Another Commissioner commented that he would hate to see the system creating a situation where an individual has to go to one facility for one type of care and to a different facility for another type of care. In that regard, he asked how rigid the system that is created as a result of CARES will be. Ms. Powers said it would not be rigid and would be able to accommodate situations such as those described.

In response to a Commissioner's question, Dr. Allen Berkowitz, Office of the Actuary, said VISNs are dealing only with the demand that VA facilities will be expected to handle. Demand associated with Military Treatment Facilities (MTFs) is not included in the model. However, he also noted that not all VA demand will be handled by VA

facilities -- DoD facilities will handle some of it -- but VA facilities must have the *capacity* to take care of all demand. Ms. Powers added that even then VA views it as "sending them there."

Ms. Powers was asked what the issues are regarding vacant space since the space could be anyplace on the grounds of a facility. She answered that the issue relates to GAO's assertion that VA was wasting money on vacant space. Consequently, VISNs will have to review all vacant space and must account for all the vacant space they have or will have -- they must do something with it. Another Commissioner remarked that VA in the past found that it often was cheaper to build new space than to renovate old space. Since this creates more vacant space, he asked what the VISNs were supposed to do with it. Ms. Powers repeated that the VISN must do something with every square foot of vacant space, including new vacant space created during the CARES process. Several options are available, but hiding the vacant space isn't one of them. Another Commissioner remarked that his experience suggests that the VISNs will *always* find a reason to renovate space rather than give it up.

A Commissioner asked where and how VA plans to handle the workload -- including Post-Traumatic Stress Disorder (PTSD) cases -- that will result from the Iraqi situation. Another Commissioner noted they should be treated close to where the people live. The Commissioner followed up by saying that PTSD is a very good example of the type of services that VA should be offering. He is concerned that new construction will inadvertently disenfranchise the highest priority patients -- those with mental health problems. He said he would not be able to buy into the CARES program if it does not provide a solution for these patients. Dr. Berkowitz responded that he would address the Commissioner's concerns later in the morning.

Another Commissioner asked how the projections took into account new veterans. He specifically asked if they were flat lined. Dr. Berkowitz replied that the *total* veteran population is declining, but the *enrolled* population is growing. Priority groups seven and eight are not growing because they are restricted from enrolling by the President's budget policy decisions. He said demand would be addressed further in an upcoming presentation. The Commissioner followed up by asking if there is a situation in the field where veterans cannot enroll at clinics. He understands that some clinics have cut off enrollment. Dr. Berkowitz answered affirmatively, acknowledging that some clinics have cut off enrollment. This was done for a variety of reasons, but resource constraints were the biggest reason until now. However, the Secretary has recently instructed clinics to eliminate their waiting lists by the end of 2003, so clinics are now seeking to reduce their waiting lists.

Format for VISN Market Plans

Ms. Powers next outlined and explained the format to be used by the VISNs in preparing the market plans. The plans will work from the highest level down to the lowest, *i.e.* from VISN level down through market level to the treating facility level. At VISN level, the plans will provide overview information, including data about markets, treating

facilities and enrollment trends. VISN-level PIs and cooperative opportunities will be listed and the networks' proposals for resolving them will be summarized by type (acute proximity, tertiary care, special disability, long-term care and vacant space).

Next, the plans will provide an overview of information at market level, including facilities information, enrollment trends and stakeholder information. Plans for resolving Access PIs will be presented at this level ("access" is the only type of PI identified at market level).

The final level of the plan will provide descriptive facility-level information and present proposed PI resolutions at the "facility" level.

The format outline for the market plans is included behind TAB B in the Commission's binders.

Q&A/Discussion

Ms. Powers was asked whether the alternatives required to be considered will be included in the market plans along with the reasons for their selection or non-selection. She assured the Commission that VISN plans will discuss all of the alternatives considered and detail the reasons for their selection or rejection. She said all of the plans will also have summaries that highlight this information.

A Commissioner asked what discretion the VISNs had in developing initiatives, i.e., how structured was the process and how much flexibility did the Networks have. Ms. Powers said that the VISNs had complete flexibility in developing solutions. The CARES National Program Office (NCPO) forced them to look at certain things, but didn't limit them as to what they could do with them. They were required to accept "demand," "space" and "cost" figures supplied by NCPO and to consider certain alternatives.

Asked whether the Market Plans the Commission will get are "VISN-level solutions," Ms. Powers said that solutions would be at the facility level. But facilities can't act alone -- they have to look at what is nearby as well as other things -- so the solutions will probably be included in the VISN-level plans. The Executive Director emphasized that the Commissioners will make decisions on the Plans. The question is whether it will make decisions about the reasonableness of Plans at the VISN, market or facility level.

**Presentation By
Smith Jenkins
Office of the Deputy Secretary
Commission Concerns**

Mr. Jenkins introduced himself to the Commission, summarizing his background and extensive experience during his 40 years of service with the VA. He is currently on detail to the Deputy Secretary's Office working on CARES, but intends to return to a VA Medical Center when his detail ends. He spoke to the concerns that the Commission has

voiced about the CARES process, including what's behind the Department's decisions, the President's budget, what's in the model and what is not and why, and unmet demand.

Regarding the *2004 President's budget* (February 2003 CARES data run with potential impact on priority group 7 & 8 enrollees), Mr. Jenkins stated that the Department had no choice in the matter, even though it might not fly in the Congress. He said enrollment was the big issue. The Secretary made that decision and next year he can either make the same decision again or re-open enrollment. The enrollment decision had very little impact on CARES -- there was a net change of only five PIs. He noted that priority groups one through six weren't affected at all -- only the level seven and eight veterans. If it becomes necessary to change the enrollment assumptions again, it will be easy to put these priority groups back in. Asked whether the impact figures took into account the "Medicare Choice" option, Mr. Jenkins said it looks like that proposal might fly.

Concerning *what's in the model and what's not*, Mr. Jenkins said that acute medicine and surgery, acute psychiatry, primary care and specialty care are all included. What's not in the model is *long-term care*. He described attempts made by the Department over a several month period to include it in the model but acknowledged that it had not been possible to get agreement -- there were too many questions and issues that couldn't be resolved for this round of CARES. He assured the Commission that long-term care isn't "falling through the cracks," but it won't be in the package the Commission gets to review. The plan is to get an approach done for long-term care by the end of the year so it can be included in the 2004 strategic planning cycle. Proposals in this category will come later and the VA will put them in the model. He suggested that if asked, the Commission should simply indicate that it wasn't given anything to consider. He further suggested the Commission might also consider including in its report a recommendation to the effect that VA should develop appropriate initiatives.

Regarding *mental health services*, Mr. Jenkins said the Department realized that the Milliman model didn't properly project demand in this area, so CARES didn't use it. But the Department didn't reduce mental health services. For *domiciliary care*, he said all the model did was redistribute demand around the country, so it was flat-lined until the problems could be worked out. Another issue is *special needs for women*. VA has some good clinics for women, but that population is growing and more are needed. They aren't included yet, but VISNs have the flexibility to propose them.

Mr. Jenkins said more special groups with special requirements will probably come up. CARES is a 20-year plan and it will be updated and changed over time.

He stated that if Medicare starts covering the cost of drugs, veterans can be expected to leave the VA and the VA will have to adjust. VA has the ability to do that -- it has already absorbed a growth of six million in workload. Asked about the process for making adjustments, Mr. Jenkins said the Department is developing a good strategic planning process at Central Office level. It will be integrated with the budget process to facilitate the necessary adjustments.

Q&A/Discussion

A Commissioner observed that the CARES process has lumped together all of the specialty care, but that the type of space and capacity requirements for each are quite different. He asked whether the model allowed VA to map demand for care at the sub-specialty level. Mr. Jenkins acknowledged that specialty care has been lumped into the model but said breaking it out would have been "too much" for this round. However, the model does map out sub-specialty care; the Department is letting VISNs plan how to handle their increased workload. The Commissioner also noted that DoD and VA had used different approaches in redesigning their health care systems -- DoD went from the bottom up and VA is going from the top down. VA is trying to get the care as close to the veteran as possible. This probably means more contracting. In response to a Commission observation that contracting out used to be the "kiss of death," Mr. Jenkins replied that people were going to see a lot more of it. Another Commissioner commented that veterans won't object if it results in better care.

A Commissioner asked about the things that are not included in the model. Specifically, he said the key is whether VA has made a policy decision as to what they will be addressing and what will be getting a fair share of resources. Mr. Jenkins said the answer is "unequivocally, yes" and invited the Commissioners to take the issue up with the Secretary at lunch.

Asked how VA plans to let Congress know that the CARES program doesn't cover the total facilities funding required for capital asset improvements, Mr. Jenkins said VA has already been telling this to Congress. The test will come in fiscal years 2005-2008 when Congress will be asked to provide substantial new funding each year. In recent years, Congress has been holding off all capital funding requests (for facility level capital asset improvements), including funding for seismic and safety projects, pending completion of CARES. The implication is that VA would have to close all of its California facilities without these improvements, but Mr. Jenkins doesn't believe this will happen.

A Commissioner asked if there was any validity to the argument that VA will never be able to get the money required to activate and run new facilities. Mr. Jenkins said that the agency is dealing only with the capital needs first. He further stated that CARES would be expensive, but not unreasonable.

Unmet Demand

Regarding the issue of *unmet demand*, Mr. Jenkins reiterated that there is no unmet demand in the model – that the NCPO has taken care of all of the identified demand. A different type of unmet demand, however, is the Commission's concern -- that veterans who are not in the system but who would be if resources were available. He said in developing the CARES model, VA always used the highest numbers available, so some unmet demand is probably built in. Additionally, there is growth in enrollment and the group being restricted is the priority seven and eight group, from which 3 million veterans are already enrolled. He isn't sure that a co-pay requirement will decrease

enrollment or that the restrictions will continue. VA expected the people enrolled in "TRICARE for Life" to leave the system, but it isn't clear that they have done so. He agrees with those who say that VA would get more patients if it had more clinics in more places. He also believes VA will be able to deal with the unmet demand if it gets the facilities it requests.

**Presentation By
Allen Berkowitz, PhD
Office of the Actuary
Unmet Demand and Mental Health Issues**

Dr. Berkowitz followed up on the discussion of his presentation at the March meeting on two major issues raised by the Commission: "unmet demand" and "mental health services." He acknowledged that the model does not cover demand that would fall in the category of "If you build it they will come" but said the model does project growth -- from 4.2 million enrollees in 2001 for priorities one through six to 5.2 million enrollees in 2012. He also acknowledged the validity of Commissions concern about the systematic under-estimation of demand for mental health services stemming from differences in how the private sector and the VA classify certain types of patient stops. He has researched the data presented by a Commissioner in April and agrees with his findings (although the Commissioner now believes that even those figures were under-estimated).

One issue with the Milliman demand model, which is complex, is that a substantial part of the VA outpatient mental health workload has no comparable private sector data because it is long term. Milliman explains the difference as being based on "age," claiming that older people in the private sector use mental health services less. VA experts do not believe that assumption applies to the population it serves, however, and is reluctant to plan for a decrease in clinic stops. World War II veterans may not use mental health services, but Vietnam veterans do. In the absence of data, NCPO flat-lined the projection for mental health services wherever it dropped. Where there was growth, NCPO kept the higher number and told the VISNs to plan for the growth. Dr. Berkowitz provided a table showing 8.947 million outpatient mental health clinic stops in 2001 (VA data). The model projected overall growth to 9.253 million stops in 2012. VA adjusted this projection to 10.580 million stops by flat-lining negative growth. Additional work on the model is ongoing.

Q&A/Discussion

A Commissioner emphasized that his main concern is that the VA does not disenfranchise that part of the veteran population that needs access to mental health care and other long-term health care services. The VA goal should be equitable access across the Nation; VA should provide a consistent package of medical services where the veterans live. He now feels that the March estimate may have under-estimated the discrepancies in the model by not counting one stop code (with 285,000 patients) and not

counting methadone visits. Together, these total 2.263 million visits, or 32 percent of the total. He doesn't want to get involved in the age argument. For him, the issue is that private sector data just doesn't count this kind of workload, which is workload that is real for VA. He believes the problem may be with the billable data base codes (CPT codes) as compared to the private sector -- VA may be under-estimating some gaps.

Another Commissioner asked whether the gap might be explained by the fact that mental health care in some VA primary care facilities is provided by an internist, resulting in erroneous coding. In response, the Commissioner said that he would have to look at the diagnosis and procedure codes to answer that question, but he has the impression that isn't a real problem because the results would be comparable to private sector data. His main concern is that VA is missing veterans in terms of demand.

Noting a wide disparity in the data from VISN to VISN, a Commissioner asked what type of validation was done on the model presented in his handout. Dr. Berkowitz replied that the table compares actual figures to the model. Where the actual demand was higher, the figures were kept. Where they were lower, the figures were raised to reflect the results of the model. Dr. Berkowitz explained that the dramatic changes he is showing between 2001 and 2012 come from increases in enrollment in some market areas.

In response to Commission discomfort about the disparity in projected growth by VISN, Dr. Berkowitz agreed to break down the numbers for both mental health and primary care and provide an explanation to the Commission by mail. A Commissioner said the real concern is what kind of data validation is being done; he hopes that NCPO is not relying on the Commission to either validate their data or find their errors. Dr. Berkowitz replied that the VISNs and Milliman have had extensive discussions about data validity. He said there is no "tweaking" going on and believes that explanations can be provided.

In response to a Commissioner's question about whether VA cut back on its mental health staff when it made cuts, Dr. Berkowitz said he had heard that same assertion but had no direct knowledge of it. He did say that even if the assertion is true it would have no effect on the model.

In response to a Commission question about the availability of mental health services at Community-Based Outpatient Clinics (CBOCs), Mr. Jenkins stated that all CBOCs of a certain size will be required to include mental health services. That policy decision is reflected in the central guidance provided by the NCPO. A Commissioner expressed the view that if VA is opening a large facility it should ensure that mental health services are provided by a medical specialist, not by a social worker.

Another Commissioner asked why the model is projecting growth when common sense would indicate that the World War II and Korean veterans will be disappearing. Dr. Berkowitz replied that while there are 25 million veterans, only 6 million are enrolled in the VA system, leaving a tremendous pool of non-enrolled veterans. When enrollment was made more attractive, people started to enroll. Overall enrollment does begin to decline, but not until 2014.

**Address By
The Hon. Anthony J. Principi
Secretary of Veterans Affairs**

Outline
of
remarks

The Honorable Anthony J. Principi
Secretary of Veterans Affairs

Vision for CARES
CARES Commission lunch
April 2, 2003

The goal of VA's CARES project is clear ----- transformation of VA's legacy healthcare facilities, inherited from the last, or even the 19th, century, into the infrastructure we need to provide 21st century medical care to 21st Century veterans.

VA's CARES team, at both the local and national level, will do the research and evaluation needed to generate "planning initiatives" to make that transformation a reality. The Undersecretary for Health will evaluate those planning initiatives, synthesize them into a national perspective and present me with a national recommendation. I will make such amendments as I believe are appropriate and then present the national plan to you for your consideration.

The role of the CARES commission is not to define the breadth or depth of VA's healthcare mission. The extent to which VA provides healthcare is defined by the resources made available. The President and the Congress make that decision.

One segment of the resources available to us is comprised of our infrastructure.

Just as we do veterans a disservice if we utilize appropriated funds ineffectively or inefficiently, so do we do veterans a disservice if we continue to support facilities that are not longer efficient or effective because they were designed to provide care in ways now rendered obsolete, or because they are inappropriately located because of changes in veteran demographics, or because they are simply redundant.

These criteria will be incorporated into the plan that I will present to you. I am calling upon you to look at the plan presented to you with new and independent eyes, to give the plan a “reality check” to ensure that those of us who are inside the system haven’t been so close to the plan and to our work that we overlook important facts or concerns.

I am not calling on you to conduct a “de novo” review of VA’s medical system. Such a review would require resources, data, staff, expertise and time beyond that available to you.

A decade ago, the so-called “Mission Commission” evaluated the missions of VHA facilities and prepared an extensive report that I will summarize as “everything is fine, send more money”. That report has done little but gather dust. I want your commitment of time and effort to be rewarded with action, not dust. Veterans will be best served if our report, and your evaluation of the report, accept the reality of limited resources.

Nor will it be useful to base your analysis on speculation on the possible effects of future events overseas on the number of veterans, or that incidents in this country may create the need for domestic healthcare resources. In this war, I am informed that DoD is turning to TRICARE, that is, to the private sector healthcare system, for its primary backup. In the event of mass domestic casualties, no matter how caused, VA will support the National Disaster Medical System. But our primary mission is healthcare for veterans and the cost of sustaining infrastructure that is inappropriate, redundant or excess to that mission will be borne by veterans who would otherwise receive VA care.

However, the CARES process, and your analysis of the product of that process, is not simply an exercise in identifying hospitals for closure or downsizing. The goal of the report you will receive and evaluate is to identify ways VA can best utilize our necessarily limited resources of facilities and funding to provide quality 21st century medical care to the veteran population of the new century.

The CARES report will necessarily include initiatives for modernizing, expanding, or even constructing facilities. I believe our experience in the Chicago area from the network 12 CARES pilot is illustrative. In Chicago, the Lakeside inpatient facility will be replaced by an outpatient facility; the Westside hospital will have substantial new inpatient construction with updates at our other facilities.

We have to remember that VHA facilities today are the product of individual decisions made over a century of time. We have buildings built to provide healthcare in places, and means, that may no longer be appropriate, much less optimal.

For example: Many of our facilities were built as large TB hospitals or long term psychiatric hospitals when the standard of care was to simply warehouse patients in isolated rural areas

Many of our facilities are located in the districts of powerful members of Congress who are long dead without regard to current, much less projected, concentrations of veteran population.

Similarly, after WWI, VA built facilities on the grounds of army forts that were built on locations chosen to fight Indian wars in 19th Century ---- those locations may, or may not, be the best place to treat veterans in the 21st century.

The practice of medicine has changed since almost all of our facilities were built.

The move from inpatient hospitalization to outpatient care reduces need for acute inpatient beds and past VA construction to provide care now obsolete can today result in excess or redundant inpatient capacity in large cities or even rural areas. Similarly, Population migration: north to south, east to west, ---- can lead to imbalances in the location of our facilities, and hence our ability to treat veterans.

The bottom line is simple: Inappropriate (because designed for now outmoded care or because of location) infrastructure consumes resources that could be, and should be, put to better use in providing healthcare to veterans. VA will produce a report that will identify opportunities for improving our ability to provide quality healthcare for veterans by more effective deployment of physical resources. I want this commission to examine that report with a critical and independent eye and report back to me on the validity of those opportunities.

Q&A/Discussion

One Commissioner expressed amazement at DoD's decisions regarding returning casualties, noting that the VA has excellent spinal cord injury care and that the sooner the casualties get into the system the better off they will be. The Secretary said the basis for the DoD decision may be the proximity of care to the service members' homes. He has asked to discuss the matter with DoD. In the meantime, VA has veterans who are waiting in line for service; it already has enough challenges.

Another Commissioner expressed his reservations about data deficiencies in the model and the exclusion of long-term care. He said he doesn't want the high-priority patients that aren't included in this round of CARES to lose their place in line for resources. The Secretary said his policy is that long-term care is vital to VA's mission and VA will continue to emphasize it. It is an important part of what VA does. He has asked that a long-term care model be developed for use in the next round of strategic planning.

Asked whether he would accept the Commission's recommendations in total or not at all, the Secretary said he could accept or reject it, or he might ask for reconsideration of some recommendations. But he wants to avoid politicizing the Commission's report.

A Commissioner asked the Secretary about the chances of getting favorable consideration of VA construction requests from OMB and the Congress, since these requests have consistently been put on "hold." Secretary Principi said he understands the arguments, but is concerned. When the CARES process is complete, the VA will require an investment in infrastructure that will cost in the billions. He intends to fight hard for this investment commitment, even if it is over many years.

In response to other Commission expressions of concern about the realities of the situation, the Secretary said that CARES is a continuation of the good things that have been going on in VA over the past decade, beginning with opening the outpatient clinics. He said he slowed the process down and thinks the process will work well. He wants the Commission to help by recommending how best to provide quality care, not just by rubber stamping or validating the plans.

One Commissioner said it will be important to tell local people that their interest and concerns are being considered as part of the CARES process. Another said that the feedback from the State Directors' conference indicated they had been very impressed with their involvement in the process.

One Commissioner said it will be especially difficult to tell small facilities that they are not providing care at the level of quality required and that a decision is being made to move the facility or contract out the care. The Secretary agreed, saying it will be both difficult and necessary. Isolated medical centers, especially old Army centers, present particularly tough issues, such as where to relocate the care. The dilemma is how to balance all of the competing interests. But the cost of excess infrastructure -- maintaining empty buildings and grounds -- is enormous.

The Secretary was also asked if there is a parallel process to CARES for acquiring the major equipment that will be needed for the new facilities. He replied that the process is still informal, but it has been started. The current market plans won't address these needs.

**Presentation By
Dr. Robert Burke, George Washington University, and
Thomas E. Mannle, Jr., Pilot Consulting Services**

Mr. Larson introduced Dr. Burke and Mr. Mannle who have recently been hired as experts to review and evaluate the CARES model on behalf of the Commission. Dr. Burke is with the George Washington University School of Public Health and Health Services and is experienced in the design and modeling of public health systems. Mr. Mannle is an independent health systems consultant who has extensive experience with VA policies, analytic efforts and data sets. They will present and discuss their findings at the May meeting of the Commission and, based on that discussion, prepare and submit a full report by the end of May. The Commission will review their report and make a decision about the reasonableness of the model at its June meeting.

Dr. Burke noted that he and Mr. Mannle have reviewed 4,200 pages of documentation about the model to date and turned up lots of questions. Mr. Mannle reviewed their list of tasks and asked for feedback from the Commission regarding what else needs to be addressed. Their goal is to give the Commission an objective, third-party evaluation of the CARES demand model used by NCPO and assess the extent to which the underlying models address the needs. They already have the essential documentation with detailed descriptions. The plan is to review the data and talk with experts in NCPO, Milliman and

VHA. They will ask about what the model is, where it came from, what problems it is trying to solve and what the model's predictive capability is. They will look at specific data and assumptions regarding enrollment, health care utilization and cost factors. They will also consider what alternatives were looked at and what issues or unexpected outcomes arose.

In terms of the *overall model approach*, Mr. Mannle said some of the questions they will be pursuing are:

- What special VA components did Milliman incorporate?
- How were VA and non-VA data sources adapted?
- What types of modeling were being used? What methodological perspectives?
- What testing was done to validate the components of the model?

Regarding the model's *predictive ability*, the review will look at:

- How were the numbers used?
- How sensitive is the model to small changes in numbers?
- How did the modelers ensure they were comparing apples to apples? Why wasn't another population sought that looked more like the VA population?
- How do projections compare to actual figures?

Dr. Burke and Mr. Mannle will give special attention to the three major components of the model: enrollment, utilization and cost. For *enrollment*, key questions to be reviewed include:

- What assumptions did Milliman make and why (in regard to migration, for example)?
- How is variability in national and VISN trends incorporated into the model?
- How do endogenous factors such as marketing affect the model?

Key *enrollment* questions to be checked out are:

- Why the "pool" method of projecting enrollment was used instead of other methods? Why didn't Milliman just re-do the Vet Pop estimates?
- How the model handles different enrollment rates for males and females?
- Why the model uses monthly projections instead of annual estimates?
- How many and which counties were left out of the enrollment calculations?
- What data issues and anomalies arose and how were they resolved?
- Why VA data wasn't used when it exists or why private sector data wasn't at least embellished with VA data?
- Why the estimates are so driven by adjustments?

Mr. Mannle said some aspects of the model are just very vague. The problem is that if the inputs are vague, the outputs will also be vague. He will ask what validation tests were done to justify using different populations. He hopes Milliman will provide answers to these and similar questions about the model. He hasn't been able to find the information in what he has seen so far.

Q&A/Discussion

One Commissioner said he thought that many of the questions listed for discussion have already been asked and answered. Mr. Mannle replied that they have an obligation, as independent experts, to check these things out for themselves. Dr. Burke added that their concern is to be able to work with the model in order to give the Commission good independent advice. They are committed to the model; they just want to know where its weaknesses are.

Another Commissioner stressed that the reports will have to be in laymen's language to be understandable. Mr. Mannle agreed that they would be, but noted that they are required to get into the technical details. By the end of April they expect to have what the Commission is seeking.

The Chairman observed that if it turns out the Commission isn't comfortable with the model; it will have a decision to make. Mr. Larson reminded the Commission that their obligation is to determine whether the model is reasonable and sound, not whether it is the best model. This decision is one of the Commission's three key decision points.

Utilization and Cost Questions

Dr. Burke next delineated his concerns regarding the model's utilization and cost data and analyses. His questions and concerns include the following regarding the sources of the model's *utilization data*, which derive from various surveys in addition to the Veterans Population (VetPop) survey:

- Whether it is appropriate for the model to rely on self-reported data?
- The extent to which private data is used to calculate veterans' utilization?
- What use was made of Medicare files -- why weren't Medicare Standard Files used after 1996?
- Why was the VA patient classification system not used?
- What are the statistical limitations of the survey used in the model for "reliance" and "morbidity?"

Dr. Burke said he is concerned that the model doesn't give VA credit for things they do more efficiently (such as technology). He will also be looking into how and why the model uses non-VA benchmarks, how the Hospital Efficient Index is interpreted (utilization rates appear to be heavily driven by management coefficients) and how well the model takes into account the fact that veterans tend to be sicker than the general population.

Dr. Burke's concerns with the cost assumptions used in the model are that they appear to be enrollment based. He will look into what cost assumptions were used and why, and what the units are for which unit costs are being estimated and what standards of reasonableness were applied. He would also like to know:

- Why the "Cost Distribution Report" (CDR) was used instead of the VA Decision Support System (DSS). The CDR is known to have flaws in its cost allocation procedures.
- Why the model uses average wholesale prices rather than VA-negotiated supply costs for pharmacy cost calculations.
- What the relationship is between "costs" in the model, "expenditures" in the model and the VA internal budgeting process Veterans Equitable Resource Allocation (VERA).

The key cost issue is whether the model is reliable when it comes to that factor.

The range of possible decisions available to the Commission resulting from the review and analysis includes:

- (1) Discontinuing use of the model and starting over (if recommended, an alternative approach would be proposed);
- (2) Continuing to use the model but with modifications or controls; and
- (3) Continuing to use the Milliman models without modifications or controls.

Dr. Burke and Mr. Mannle said they would like to hear more from the Commission about what the review should address so they base their work on the Commission's needs.

Q&A/Discussion

Individual Commissioners asked for the model review to include the following:

- A statement about what the total need for care is and that relates demands to that need.
- A review of the validity of the assumption that there is no way to determine whether veterans will migrate from priority group eight as they age because of financial need (Dr. Burke agreed that the current documentation doesn't address the basis for this decision).
- A "reality check" on why the number of enrollees doesn't decline with age.
- An opinion about whether it is correct to be using the number of enrollees to project demand when there are more enrollees than users. Additionally the crossover between VA and Medicare should be reviewed.
- Whether the model really meets the need for VA's hallmark specialty care, including traumatic brain injury and spinal cord injury and disorder.

Academic Affiliate Stakeholder Presentations By:

Dr. Stephanie Pincus, Chief Academic Affiliations Officer, DVA

Dr. Jordan Cohen, CEO, American Association of Medical Colleges

Dr. Geraldine Bednash, Executive Director, American Assn. of College of Nursing

Dr. Pincus stated that her office leads VA's teaching mission. VA's educational mission came to the fore immediately after World War II. In 1946, VA had 98 hospitals with fewer than 84,000 beds and no residency program. Between 1942 and 1980, VA grew

very rapidly -- from 97 hospitals in 1942 to 151 in 1950 and 172 in 1980. By 1980, over 70 VA hospitals were within five miles of a medical school. This is important to CARES; many VA hospitals are physically connected to their academic affiliates. Changes and impacts that happen at VA hospitals have direct and immediate implications for the affiliates and their academic activities. While VA growth has occurred all over the country, trends in population distribution have demand currently growing more rapidly in the Southeast and Southwest. The VA is, and the Commission also will be, struggling with this geographic mal-distribution .

VA is an essential part of American medical education. VA has affiliations with 107 of the 125 U.S. medical schools -- many of them clustered in the northeast. Fifty-seven percent of American medical students rotate through the VA during their medical education. VA also has over 5000 affiliations with associated professions (such as audiology, dentistry, dietetics, nursing and occupational therapy) that involve 32,000 trainees a year. Each year 15,000 medical students and 28,000 residents rotate through VA -- about 38 percent of the total residents for all specialties. VA is the number two payer of salaries for medical residents, however, VA does not have its own freestanding residency program. Instead, it has formed partnerships with the medical schools.

The main question is, "What will the concepts that come out of CARES do?" CARES has broad educational implications, for VA's educational mission, for its affiliates and for its other associations. The key word is collaboration. For VA, the challenge will be to continue supporting the teaching mission as facilities are realigned while at the same time meeting veterans' health care needs. This has to happen no matter what VA does.

Medical school deans are concerned that their students continue to get appropriate clinical training. Dr. Pincus related the experience with the VISN 12 pilot, where Northwestern and the University of Illinois, each of which have their own VA hospital, wound up having to share.

Another consideration of importance to affiliates is whether VA has enough patients with the right kinds of conditions. The affiliates may need VA patients to run an accredited program.

Because VA is decentralized, decisions will be made at the local level. The local leadership has the best sense of what is appropriate for their area. However local decisions need to consider what is best for the system as whole. The NCPO put together a set of guiding principles for localities to consider as they go forward. One is that the decision should create a health care system that provides the best environment for patients and trainees. There must be a commitment to patient care, education and research. There must also be a commitment to value, quality, accountability and patient satisfaction. The localities should communicate directly to build mutual trust. It is also important to create a scholarly environment because that is one of the essential features of VA. The difference between VA and a community hospital is that VA is a scholarly institution and that benefits VA's patients.

Dr. Pincus said the key issues for her Office are:

- Resident work hours. In 2003, all VA programs across the country will have to adjust their operations so residents are not required to work more than 80 hours a week. This will improve the quality of care and also make sure that trainees are able to take best advantage of their education.
- Physician time and attendance reporting. This issue will have an impact on work relationships.
- Physician pay. VA is attempting to raise physician pay.
- Workforce shortages. There are nursing shortages everywhere as well as shortages of selected physician skills.
- Financial and billing pressures.
- Renewed emphasis on tertiary care.

Her recommendations for the future were to (1) monitor and evaluate the impact of CARES on affiliates so VA can make course corrections when called for; (2) aim for consistency while accepting local requirements; (3) develop flexible mechanisms for making adjustments; and, most importantly, (4) value the partnership.

Dr. Cohen said his organization represents 126 medical schools (of which 107 have formal affiliation agreements with a VA facility), 400 teaching hospitals and 92 academic and scientific societies representing nearly 100,000 faculty, medical students and residents. He said the formal affiliations are vital to both the medical schools and their VA partners. His presentation covers: (1) the major issues facing medical school affiliations with VA facilities; (2) the potential impact of new resident work hour regulations on the affiliations; and (3) the potential impact of VA's shifting of care to outpatient clinics.

The affiliation agreements began in 1946. Since then, VA health care has been intimately linked with affiliated medical schools. The relationship has been mutually beneficial -- VA gets access to a higher standard of medical care than it could achieve with a full-time VA medical service and the medical schools gain opportunities for medical education and research. There have been both good and bad times and both sides have had to work to keep the relationship healthy and productive. Open communication is the key. Dr. Cohen said the VA-Deans Liaison Committee of the American Association of Medical Colleges (AAMC) meets regularly to discuss areas of mutual concern. Because VA always attends a part of these meetings, the Committee has become an invaluable forum for discussing and debating major issues. He emphasized that CARES has been a frequent topic of discussion for the group.

CARES will impact the affiliates that share facilities and faculty. From the perspective of the academic affiliates, Dr. Cohen said the Dean's Committee is skeptical that VA's *education and research* missions are receiving adequate attention in the CARES process. His organization recognizes that VA's core mission is patient care but believes that education and research are integral to delivering high-quality health care and are critical elements in making VA one of the best health care systems in the world. The experience in VISN 12 has also led to the concerns that the affiliates are being shut out of the process

and that assumptions about affiliates' reactions are being made without appropriate consultation. VA leadership has been very receptive to the AAMC's concerns, but many deans are still wary.

The most problematic issue facing the partnership right now is part-time physician *time and effort reporting*. The problem -- inaccurate reporting of times that physicians were required to be physically on site at VA facilities -- appears to stem from a woefully inadequate reporting system, not intentional fraud. AAMC recognizes this as a serious problem -- mistrust has begun to creep into the relationship. AAMC is concerned that VA inflexibility about adhering to unworkable rules coupled with the fear of prosecution has begun to impede the recruitment of physicians to joint appointments. This has been a major topic of discussion by the Deans' Committees. His organization is working with VA to develop a system that meets the needs of both parties.

A third issue of concern is *intellectual property*. The VA Medical and Prosthetics Research program has been a valuable asset to both VA and academic medicine. Tangible benefits of research are being realized in improved care for veterans, and VA is recognized as a world leader in spinal cord, prosthetics, geriatrics and rehabilitation research. VA seeks to ensure that its research products provide maximum benefit to veterans and to re-coup some of its substantial investment by claiming ownership rights to inventions produced with VA resources. To this end, VA asks affiliates to sign Cooperative Technology Administration Agreements, which set forth the terms for handling joint inventions with academic affiliates. While there is no question that VA is entitled to an appropriate share in the intellectual property to which it has contributed, Dr. Cohen said the manner in which VA has pursued the issue has caused consternation on the part of several deans. To many, the VA has appeared as overreaching, particularly in cases concerning WOC appointed researchers. However, the positive working relationship between VA and the AAMC provides a forum for seeking a solution. VA leadership has said it is willing to let affiliates renegotiate their agreements if they need to clarify terms. Recent discussions indicate that progress is being made on resolving this issue.

Concerning the issue of *resident duty hour limits* and how it will affect affiliations, Dr. Cohen said he expects minimal impact for most specialties, although there is no easy answer overall. Most residency training programs in most disciplines operate well within the 80-hour weekly limit. The surgical specialties are most likely to be impacted by the limit. There is even widespread speculation that some surgical subspecialties may be thinking about removing their residents from the VA to comply with the rules. Such a move would require VA to contract for services at a higher cost and would deprive residents of the rich source of the training opportunities VA provides. He emphasized that the Association has not heard of any definite plans for such a move. Another potential impact of the new duty-hour limits may be to curtail some of the current "moonlighting" opportunities for residents. Further, many teaching hospitals are hiring additional personnel (such as physicians assistants) to handle some of the workload resulting from the limits. There are concerns about who should pay for these additional

providers. Dr. Cohen also noted that small affiliates with low resident numbers may be harder hit than larger affiliates.

The impact of VA's *move to outpatient care* at CBOCs, another question Dr. Cohen was asked to address, varies from facility to facility and from region to region. Where veteran numbers are declining, as in the Northeast, the smaller patient base causes problems for some academic programs. The obvious solution -- resident travel to CBOC sites -- raises other problems such as paying for travel time and costs. The biggest impact of the shift on affiliates might be the likely reduction of jointly appointed VA faculty in favor of full-time VA physicians. While academic affiliates would likely have the opportunity to contract for these services, it would change the dynamic of the relationship -- contracted services might be less economical and contracted physicians would not be eligible for research funds.

A common saying is "If you've seen one medical school, you've seen one medical school." The same might be said for affiliation agreements -- all are different. But there are some common perceptions. One is that the VA shift from hospital-based care to outpatient care has reduced the importance of the VA's education and research missions. Another is that issues such as those already discussed have strained the relationships between VA and its affiliates. The requirement for deans to maintain relationships with VISN directors as well as local medical center directors has compounded the strain.

Dr. Cohen concluded by informing the Commission that his organization would welcome a strong affirmation by both partners of the benefits to be derived from a close working relationship. It is also vital for VA's medical school partners to be included in the decision making process.

Dr. Bednash, representing the American Association of the College of Nursing (AACN), said that she is a veteran and VA has been very important to her career -- she trained in VA facilities both as an undergraduate student and a graduate student.

VA and its facilities continue to play an important role in the education of nurses. One of the focuses of her organization is the entry-level education of the professional nurse. Her organization is having a major debate about the role of professional nurses in a changing health care system. The issue is how to provide quality care in any environment. Another major focus is on care of older adults and there is increasing emphasis on geriatric care at both the graduate and undergraduate level. Directly related to VA is the fact that four years ago the AACN signed a memorandum of agreement with the VA to facilitate education of the VA workforce. Under this contract the AACN brings educational programs to VA facilities to help its staff acquire undergraduate and graduate nursing degrees.

Dr. Bednash emphasized that VHA facilities are an important resource for educating American nurses. They provide critical placement opportunities for new nurses. After a six-year downturn in enrollment, nursing schools have recently experienced a two-year upturn. Even so, there has been a contraction despite a constant demand and efforts to

bring more students to nursing. For the schools, the problems involved in attracting qualified applicants are (1) the lack of faculty and (2) the lack of clinical placement opportunities for working students. As a result of current conditions, over 6,000 qualified applicants were turned away two years ago and 4,000 qualified applicants were turned away this year. Accordingly, many of these people likely decided to pursue other career options. VA facilities are important to resolving the placement issues. Currently there are 600 affiliations with VA community clinics and health care centers. In addition to placement, these affiliations provide important mentor and faculty roles for nursing students. The relationships are critical to generating the workforce that will be needed for the health care system overall. The AACN is also concerned about the possible contraction of nursing research, much of which is supported by VA.

Dr. Bednash said that nurses who come to the system will stay with the VA if it provides positive learning experiences, even though there is no requirement that they stay in the VA after they have completed their baccalaureate. She hopes that VA will recognize the importance of maintaining nursing programs at a high level.

Q&A/Discussion

A Commissioner noted that the Secretary indicated that DoD might be sending patients from Iraqi Freedom back to TRICARE facilities rather than VA facilities, commenting that what he has heard from the presenters would indicate that this decision would not only bypass VA's excellent services in specialty care but would also deprive the medical community of needed training opportunities.

In response to a Commission question, Dr. Cohen said the shift to outpatient care is a general trend going on throughout the health care system -- it is not unique to VA, but VA is a big part of the system. The structure of VA and their affiliations with University medical schools is presenting significant challenges -- VA is a big part of the medical school system. He said a lot of different approaches are being tried, but the real need is to reengineer the medical education system.

A Commissioner commented that the numbers cited by Dr. Pincus -- 80,000 health care professionals trained in the VA system annually -- indicate that VA is a very critical part of the overall medical education system and he sees one of the Commission's responsibilities as being to take special care to support that effort.

Another Commissioner commented that he had never met doctors or nurses who were trained in the VA system who weren't pleased with their experience. But he said he still needed to learn more about what is involved in the relationship beyond patient care.

One Commissioner cited a book by Bill Middleton entitled "Ring the Night Bell," noting that it tells what things were like in the VA before the 1946 change that resulted in VA affiliations with medical schools. He said it helps show very clearly why the medical schools and the VA need each other.

In response to a Commission question about whether medical schools are moving in the direction of tele-health, Dr. Cohen said there is movement but it is spotty. Clearly information technology will be a big factor in overcoming the challenges involved in the shift to outpatient care, but no one has yet solved all of the problems associated with it. Telemedicine is still in its early stages and offers huge opportunities for partnerships. Dr. Pincus added that it is high on the agenda of the Under Secretary for Health, along with hospital-based home care. Dr. Bednash said the nursing curriculum is not based around any particular setting; nurses have to adapt to any setting to deliver health care across a continuum. Quality is the main driver for the AACN.

Citing the case of the CARES pilot program in VISN 12, a Commissioner noted that VA didn't take advantage of the opportunities provided and, as a result, Northwestern Medical School is no longer an affiliate. He asked if Dr. Cohen had any comments about that experience. Dr. Cohen said all of the schools recognize that VA has the right to re-orient its capital assets and that patient needs have to be the primary driver of the decisions. His organization only asks that VA keep the affiliates in mind as CARES progresses. The medical schools would like an opportunity to make their case.

Asked if the medical affiliates have had an adequate opportunity to participate in the CARES process, Dr. Cohen said it is still too early to tell. Dr. Pincus said her office sent letters to the deans of every affiliate as well as to the VISNs suggesting that they contact each other. She thinks this may have worked in some cases, although maybe not all.

Responding to a Commissioner's comment that there may have been a slip in communications between the VISN Directors and the medical center directors, Dr. Pincus noted that 10 years ago every VA facility had an individual ("Associate Chief of Staff (ACOS) for Education") who was responsible for education programs. This is no longer the case, and this makes the deans feel isolated. In VISN 12, it was recommended that this position be re-established. She suggested the Commission might want to consider suggesting that this position be re-established system-wide.

Another Commissioner observed that he had been involved with the VISN 12 pilot. His experience was that the medical school programs in at least one state were not only reinforced as part of the pilot, they were enhanced.

Dr. Bednash said nursing schools have a different relationship with VA than the medical school affiliates and she hopes they have been involved in the CARES process. For VA, relationships with nursing schools are an inexpensive option because nursing students don't get paid. Funding is not available for nursing students as it is for medical students. For nursing students, access to facilities is the major concern.

In response to follow-up questions about how the inadequate time reporting system for residents would be solved, Dr. Cohen said the issue is being addressed. Dr. Pincus added that VA is really struggling with the issue. The question is how to create a system that will work for the medical schools and the VA. Today, a lot less work by physicians is

done "on site" that formerly was not. VA is working on new approaches to address and adapt to this change.

A Commissioner asked Dr. Bednash if it is difficult for VA to participate at the local level in some of the innovative programs that are going on in various places. Dr. Bednash replied that it varies from locality to locality. She said there is a general openness, but no uniform approach. Improving the response system-wide will require support and leadership.

Thursday, April 3, 2003

Chairman Alvarez announced that the Secretary has appointed Dr. Layton McCurdy, past Dean of the Medical University of South Carolina, to the Commission, putting the total number of Commissioners at sixteen.

He also announced a realignment of Commission Teams and the appointment of Lead Commissioners. Commissioner Ferguson will lead Team One; Commissioner Vogel will lead Team Two; and Commissioner Battaglia will move to Team Three as the Lead Commissioner. Commissioner McCurdy will join Team Two.

The Commission's agenda for the day is to hear from stakeholders and begin Team reviews of workload capacity gaps and Planning Initiatives in the various VISN-based geographic areas.

Stakeholder Presentations By:

Deborah Beck, The Nurses Organization of Veterans Affairs (NOVA)

Dr. John F. Burton, Jr. DDS and

Dr. Kathy Udell-Martin, DDS, National Association. Of VA Physicians and Dentists (NAVAPD)

Ms. Beck represents NOVA, the professional organization of the approximately 35,000 registered nurses employed by the Department of Veterans Affairs (DVA). NOVA's mission is to shape and influence health care within DVA. NOVA supports the mission of CARES, a program designed to enable the veterans' health care system to more effectively use its resources and deliver more care to more veterans in places where they need it most. NOVA also applauds the Secretary for making CARES one of his priorities and for moving it forward at a rapid pace.

DVA has the largest nursing workforce in the country with over 55,000 registered nurses, licensed practical nurses and nursing assistants. VA is facing an unprecedented nursing shortage, which could potentially have a profound impact on the care given to veterans. VA's nurses are an important resource in delivering high quality, compassionate care to veterans. VA must be able to retain and recruit well-qualified nurses to continue that care. The role of the Commission is to make recommendations to the Secretary about the VA infrastructure, but the heart of the VA is not 4,700 buildings and 18,000 acres of land. Its greatest asset is the health care team that works together to care for the Nation's

veterans. The primary motivation of VA nurses is to provide quality care to their veteran patients. A recent survey found that 90 percent of respondents said that the most rewarding aspect of their job was caring for veterans.

VA is now facing a nursing shortage of unparalleled proportions. Compelling statistics include:

- Only 23 percent of VA RNs are under the age of 40.
 - The average age of the VA RN new hires in fiscal year 2000 was 41.65 years.
- The VA is experiencing difficulty in recruiting nurses. The national nurse supply will continue to decline. VA nurses will be eligible for retirement in large numbers through 2005 -- 35 percent of RNs, 29 percent of LPNs and 34 percent of nursing assistants. Nationally, the nursing workforce is aging -- the average age is 45.2 years; for VA the average age is 46 years. To ensure care for the aging veteran population in 2010 and beyond, it is critical that DVA be able to recruit nurses as well as retain the nurses already in the system.

In the past decade there has been a shift in the delivery of care as VA has moved from an inpatient to an outpatient system. The opening of Community-Based Outpatient Clinics (CBOCs) has had a positive impact on the care of veterans. It has increased cost-effectiveness and has improved access to health care. It is believed that VA should continue in the direction of increasing the number of CBOCs throughout the system. Nurses find this a superior environment in which to provide care. For example, when one nurse requested a transfer, a number of patients requested to move with her. The increased availability of clinic appointments has resulted in patients being seen within 48 hours of the requested appointment. Patient satisfaction survey results have been excellent with patients expressing appreciation for the availability of these clinics in their community. They have also been complimentary of the care they receive. In an effort to improve access, nurse practitioners are utilized as key decision-makers in four nurse-managed primary care delivery clinics across one VA health care network. These CBOCs utilize nurse practitioners with prescriptive authority.

VA nurses in the fields also have concerns related to CARES. Comments gathered at the Association's annual meeting last week include:

- The facility impacts the quality of care that nurses can provide to veterans. Nurses working in CBOCs said their job satisfaction improved after being transferred from an aging facility. They also believe they are able to provide better care. Nurses take pride in their work and it is difficult to be proud in an old environment with inferior equipment, mismatched furniture and technology that does not function consistently. Outdated facilities impact the morale of the nursing workforce and, subsequently, their care to the patients.
- Nurses believe CARES will profoundly affect nurses in the field as facilities are closed or consolidated. Nurses have questions about how these actions would impact the mission of the VA. For example, if a medical center becomes strictly an outpatient facility or a nursing home, acute care nurses might not be prepared for or satisfied with working in a non-acute setting. More education and training for the nursing staff may be required to prepare them for this change in mission.

- As facilities are closed, job satisfaction may decrease, which could lead to recruitment and retention problems. Both nurses and patients may have to travel greater distances to work or to receive health care.
- As the VA tries to recruit new graduates into the system, the VA will be competing with state-of-the-art hospitals in the community. It is believed that aging facilities may impact both the recruitment and retention of the VA nursing workforce.
- The changing mission of the medical centers will affect VA nurses. The extent and scope of the impact will depend on the magnitude of the change. For example, if a facility has been gradually downsizing its inpatient services, the volume has already been decreased and the staff has been shifted to go with the outpatient services and nurses have been involved in the planning of alternate medical care for the veterans. In these cases, the needs of the frail, the elderly, use with multiple diagnoses and the mentally ill have been addressed. Conversely, if this gradual change has not taken place, and the CARES process brings about large shifts in care delivery, then the impact on the veterans will be significant. The impact on the nurses providing their care will also be tremendous. Nurses are involved in every aspect of planning and delivery of health care. Patient education for the veteran and the caregiver, in-home caregiver services are serious needs and should include nurse evaluation and recommendations.

VA nurses support the effective and efficient use of resources to provide care for veterans. As nurses, they know that it is not reasonable for a very small inpatient unit to offer the complexity of services today's health care environment requires and that veterans need. However, it is critical to involve the nurses in planning the changes, especially the nurse who will be at the bedside explaining to veterans how their care will be more comprehensive when delivered at a distant facility rather than their hometown VA medical center. It is the nurse who will provide appropriate support and education to both patient and care giver to affect a transfer with the least disruption in services.

The Association understands that the Commission will be holding hearings in each VISN in June and July. Nurses are very interested in being part of these hearings because of the potential impact on nurses in the field and their veterans under their care. The Association also recommends that the Commission consider a CARES implementation task force be formed whose purpose would be to oversee and make recommendations to the CARES Commission during the implementation phase. They would further recommend that nurses play an integral role in this task force. The nurse participant on this task force would bring critical experience and insight.

Dr. Burton represents the National Association of VA Physicians and Dentists (NAVAPD) -- some 12,000 full- and part-time VA doctors throughout the country. He characterized his organization's members, along with their nursing colleagues, as the "front-line troops." As such, they will continue be called upon to deliver the very best quality health care to veterans no matter what the outcome of the Commission's work. NAVAPD members see themselves not only as stakeholders in the CARES process from a medical specialist's point of view but also as spokespersons for the veterans under their care.

While many think of capital assets as "bricks and mortar," NAVAPD believes that the employees, both professional and non-professional, are the true capital assets of the system. Dr. Burton said there is no question there is a need to change the face of the VA. The patient population continues to change -- World War II and Korean War veterans and their health issues are becoming a smaller portion of the practice, while more Vietnam and Gulf War veterans are being seen. NAVAPD can only speculate about the impact that the veterans of the current conflict will have, but the potential is there for a substantial increase in the patient base. While the face of the system may change, the commitment made by the Nation to its veterans cannot and must not change. VA has to find the right balance of access, personal care and technology to continue to meet needs.

It is important to bring VA health care services to within a reasonable distance for veterans -- 30 miles for primary care and 100 miles for inpatient services is a laudable goal. However, simply making it convenient without ensuring a constant level of quality care will ultimately damage and possibly even destroy the system. The NAVAPD encourages the Commission to look carefully at how technology can benefit the VA system. As the Nation's largest health care system, VA needs to enable its physicians to use the most advanced medical services with state-of-the-art tools. Electronic record keeping and telemedicine are not the future; they are the realities of today. Technology must be part of the equation.

For many reasons, recruitment and retention within the VA system, particularly in certain specialties, continues to be a problem. The "quick fix" is to contract out the new services and this has become a popular practice. However, it is very costly compared to VA employed providers. In addition to cost, there is also the issue of commitment. VA doctors have committed their professional lives to serving veterans. Except for changes in technology and techniques, the veterans there will see tomorrow or next week will receive the same commitment as the patients they saw 20 years ago. VA doctors and nurses are concerned about contract providers. Dr. Burton emphasized that contract physicians provide quality care during the term of their contract. But they have no ties, past or future, to the veterans they see. This can and will affect the continuity of care.

An examination of the data on veteran population centers will show the migration to certain regions of the country. The organization encourages the Commission to withstand the political pressure to keep large facilities in areas with small veteran populations open and fully operational at the expense of areas that are seeing dramatic increases in veteran population. VA resources are too limited and precious. Dr. Burton suggested that the Commission respond to the pressure the same way that bank robber Willie Sutton did when he was asked why he robbed banks. He replied "Because that's where the money is." When challenged on the movement of assets and resources, the Commission should simply answer, "Because that's where the veterans are."

Q&A/Discussion

A Commissioner asked about the extent to which VA's line clinicians have had input to the VISN planning process and what the feedback from members has been about that process. Dr. Burton said his personal experience in South Carolina was that he was directly involved in one of the Planning Initiatives. In South Carolina there is the Columbia Hospital in the center of the State and the Charleston Hospital in the "low country." But all of the State's growth has been in the "up country" around Greenville and Spartanburg. Dr. Burton said he was involved in planning for the projected growth in that area and he was not totally happy with the recommendations that came out of the process, which concerned contracting. As a manager, he said he has used contractors as part of the services his unit provided, and he integrated them into the operation of his physical plant. He said that's a wonderful way to deal with growth as long as it's an integrated process that provides cost-effective care and quality care in an environment that's culturally sensitive to the needs of veterans.

In response to a follow-up question, he said that clinicians had been provided with the opportunity to have input, although some are not happy with what happened to it.

Ms. Beck said that she understands the opportunity to have input was sporadic for nurses, but she doesn't have information for most VISNs. She offered to check further and get back to the Commission.

Replying to a question from a Commissioner, Dr. Burton described the recruitment situation for some sub-specialties, radiology, for example, as "an impossible situation." VA is contracting for services in these specialties. It is very difficult to recruit dentists, where the turnover rate is about ten percent. The average age of a VA dentist is now pushing 50. In primary care medicine VA is doing okay right now. In the sub-specialty areas, VA's salary structure is nowhere near competitive levels so it is very difficult to recruit.

A Commissioner asked whether there was anything the Commission might do to help improve recruiting and retention for nurses. Ms. Beck answered that childcare was identified as an issue in nurse recruitment at a number of facilities. One solution involving the innovative use of infrastructure has been to partner with a local community college. VA brings in the college to use its space for teaching in return for making the courses available to LPNs. One Commissioner suggested that with the aging nurse workforce, childcare may not be as big an issue as day care for the elder parents of 45-year old nurses.

Another Commissioner suggested that VA could benefit from a public relations effort in the nursing schools to help overcome the image of outdated facilities and technology -- something along the lines of "Have you seen a VA facility lately?" He recommends reaching out to young people, even down to high school level, to talk about the importance of health care delivery and the thrill of being part of a team like the VA. He also said the military had improved the recruiting and retention of physicians and health care professionals by educating them about the differences between government and the private sector in such areas as malpractice, taxes and retirement. Ms. Beck agreed with

the need for a public relations effort, saying that her perception had been that the VA system was an inferior health care system. Once she got involved with VA nurses (she is not a nurse) she saw their dedication and realized that salary is not an issue with them. She mentioned an innovative program in Salem, Virginia, called the "nurse cadet program," that brings high school students into the VA through a very comprehensive program. A high percentage of these students continue with VA. The program is now being piloted in other areas of the country. When nurses get out of nursing school, they don't look primarily for salary. They look for opportunities where they can get more education and get into a career track

Dr. Martin commented that her facility in New York has a community-based outreach program that brings students into the VA for training. Her experience has been that continuity of care is very important to patients and is something that has been very difficult to achieve using contract dentists. She also asked the Commission to consider recommending universal dental care for veterans.

A Commissioner asked whether Dr. Burton had any figures about how many CBOCs were operated by contract staff and how many were operated by VA staff. Dr. Burton said in his area (South Carolina) they opened the first CBOC with VA staff but converted it to contract. Since then, all of the CBOCs have been contract operated. Commission staff provided information to the effect that about one-third of CBOCs nationally are operated by contract providers. Contract-operated CBOCs tend to be a little different in that they are located in universities or be the one- or two-person "doc in a box" in a very small area. VA CBOCs tend to have two or three staff and enough patients to support that. Staff will get additional data for the Commission before the hearings. In response to a follow-up question about the relative costs, Mr. Larson said that he would obtain copies of a study that was done on that subject, about five years ago.

A Commissioner noted that CBOCs are largely hospital-based and observed that CBOC staff will also need continuing education to combine with their experience. He asked if there are some good examples of CBOCs that have managed to combine education and experience in developing the staff. Dr. Burton agreed with the need, but said he didn't know of any examples.

Dr. Burton added that one of the problems with CBOCs is that individual physicians operating as contract providers may not have relationships with other specialists they can call on to get things done quickly. This contrasts with family doctors who develop networks of people whom they can call from time to time and they have working relationships with those people. VA physicians have a similar network. VA is contracting with big corporations. These big corporations have their own "system" and just hire "bodies with a medical degree." The important question is *how* VA uses the contract providers and integrates them into its system.

In response to another question from a Commissioner, Dr. Burton noted that medical, dental and nursing education is very expensive. The slots needed for the future aren't there. The states can't afford it and the private schools won't commit more money to

them. Dr. Martin added that many hospitals are using foreign health care practitioners to meet the demand. VA isn't ready to do that. She also noted that contractors don't have access to the same type of research support as VA physicians and are not under the same quality assurance programs as VA providers have at their hospitals. Most VA providers are caregivers as well as physicians -- she coordinates appointments, arranges transportation and does a lot of other things for her patients. A lot of what VA physicians do doesn't show up on the bottom line data. Contract physicians aren't allowed to utilize their time that way.

Dr. Burton answered a question about waiting times for dental care. His experience has been 90 days minimum for new patient's first exam and more often six to eight months.

Stakeholder Presentations By:

Alma Lee, President, National VA Council, American Federation of Federal Employees

Michael Boucher, President, National VA Council, United American Nurses

Ms. Lee said she will address the issues that her union feels the Commission should consider. The Union asked the employees about their concerns. Her union represents over 150,000 VA employees who provide front-line service care to veterans nationwide. The overwhelming majority of these employees work for VHA. Their lives will be directly affected by the work of this Commission. Nothing could be more important for this Commission than to hear from these thousands of world-class employees through their designated representative. The Union is aware that the VA budget is tight and has voiced its concern in other arenas about the budget cuts. That is outside the scope of this Commission, but the Union believes that the work of the Commission, if done properly, will alleviate the budget shortfall. The Union also acknowledges that the VA cannot continue to do business as it has always done, not only as a result of the budgetary conditions but also as a result of changes in the method of delivering health care.

The National VA Council, acting in cooperation with senior VA management, has been at the forefront of the transformation in veterans' health care. The issues that the employees in the field want The Commission to consider are:

First and foremost, they would like the Commission to place a human face on all of the decisions. Every hospital closed, every facility realigned has living, breathing employees who work there and who give all they have to make those facilities and hospitals world class.

The Council asks that the Commission recognize the uniqueness of the VA health care system. Many of the services available at VA facilities, such as spinal cord injury and mental health treatment, are not available to the same level in non-VA facilities. There is no organization in the world more experienced in these areas. From an economic standpoint perhaps it does not make sense to keep a facility open that provides counseling to seemingly only a handful of patients afflicted with PTSD. But at the end of the day,

VA is not in the business of economics. It is in the business of providing health care to veterans. When they need the specialized care that only VA can provide, VA should provide that care, whether or not there is an economic case for providing it. We must always remember that the VA owes its very existence to the fact that they provide a level of service not available in the private sector. We must ensure that these services continue to be provided.

The Council also asks that the Commission take into consideration that the world has changed dramatically. The potential impact of September 11, the Gulf War, the trouble in Afghanistan and the fighting in Iraq needs no elaboration for this Commission. Ms. Lee said that of the men and women who served in the Persian Gulf conflict, over one million claims were submitted and, of these, 600,000 were awarded disability benefits. This is the other side of the health care coin. The fighting in Iraq today has already been longer and more intense than the fighting in the first Gulf War. It is a truism that the more intense and the longer the fighting, the more the physical and mental the consequences. If the needs of the first Gulf War veterans, could be guessed, one would find that instead of fewer facilities, VA will need more facilities. VA can expect that there will be many more cases of PTSD. Moreover, the military now contains more women, and more women in direct combat roles, than ever before. there is no accurate prediction what effect this will have on the number of PTSD cases. Further, if there is house-to-house fighting in Baghdad, there may be a rise in spinal cord injuries. VA cannot and dare not cut back on PTSD and spinal cord injury programs at the very time our veterans may need them. Ms. Lee said she is aware of the fact that CARES is looking at facilities and not programs (such as PTSD). However, programs cannot exist without the space. Moreover, the need for more and different types of programs will render current facilities inadequate.

Another consideration arises from recent tragic events. With VA's fourth mission, as a backup for DoD, is important. No one can say with any degree of certainty what will be needed in this area in the future.

The Council asks that Commission recognize that VA is an integrated health care system in which not only large centers are important. Small facilities are often the livelihood and lifeblood of the small communities in which they are located. Again, one may not be able to make a business case for keeping such facilities open. But they provide services to veterans who otherwise would be forced to drive hundreds of miles from home to receive the care to which they are entitled.

Finally, the Commission should recognize the importance of the level of service and hard work that federal employees have given to our veterans over almost seventy-five years of VA's existence. The Union understands the pressing need for realigning the facilities. However, the employees hope that CARES will not be just a lever for moving veterans' health care from Federal facilities to private companies. The hard-working employees work long hours for inadequate pay because they recognize the debt this Nation owes its veterans. They don't believe that the care should be turned over to companies whose sole

concern is not the service they can provide to veterans but how it will increase their "bottom line."

She cited an example in Albany, New York where care was contracted out to a CBOC, resulting in many complaints about the computerized records system and miscommunications about referral patterns. A decision was made after many requests to convert from the private CBOC. She hopes the Commission will keep this from ever happening again. The Union believes that the care should be provided by dedicated professionals, not by minimum-wage workers.

Ms. Lee stated that the unfortunate fact is that AFFE hasn't been a part of the CARES process at most facilities. She stated this lack of participation will keep the system from utilizing the experience and understanding that comes from being on the front-line. She said LPNs, nursing assistants and housekeepers understand what it means to provide service to veterans. These employees have consistently said that they don't want reductions in facilities to lead to reductions in care, especially in those areas where the VA has the highest level of specialized care.

Mr. Boucher represented the National VA Council of United American Nurses (UAN)--the labor arm of the American Nurses Association. UAN represents about 6,000 registered nurses in the VA system scattered around the country.

UAN understands that the Commission is looking at the infrastructure needs of the VA for the next 20 years. His organization echoes the concerns already expressed about the nursing shortage and the need for recruitment and retention strategies to deal with it. As nurses, the UAN feels that the Commission should have some impact on a number of things in terms of the infrastructure.

One of the things they find is that there is insufficient equipment and technology of the newest type available in the aging VA facilities. He cited as an example the patient lift equipment that has been piloted in Tampa. Such equipment offers better ways to protect both patients who are being moved and the backs of the nurses who are doing the moving. The infrastructure now in place simply won't support these types of new technologies without major construction.

Mr. Boucher cited Mary Foley, a past president of the ANA, who said that it's not a big challenge to recruit nurses in markets where you have them but it's extremely difficult to retain them. He thinks the VA faces this problem. He sees two major deterrents to VA retaining its nurses: working conditions and respect. The National Commission on VA Nursing will try to make an impact on the respect issue. With regard to working conditions, one of the biggest dissatisfiers for nurses is they can't find a place to park. He thinks parking is also a problem for the veterans. VA is using a lot of innovative strategies -- valet parking, parking decks, etc. -- but parking remains a big issue. Nurses will put up with having to come to work an hour early to get a parking place for just so long before going to look for another employer. He said the nurses he represents would like the Commission to address the parking issue in its considerations.

VA also has emergency preparedness as a mission. One of the things that the VA is "woefully unprepared" for at this point are all of the things that support that mission. Examples include decontamination equipment, isolation rooms, with accompanying sanitation, for veterans for the nurses who are taking care of them. Although the weapons of mass destruction pharmacy caches are available, there is no place to put them in the emergency care areas where they are needed. During a recent disaster drill in Durham, North Carolina, where Mr. Boucher works, it took 13 minutes to move the pharmacy cache from its storage location to the emergency room. In a real incident, there might be only a couple of minutes to react. So he believes that the infrastructure changes ought to also deal with emergency preparedness needs.

Dependent care is another key consideration for nurses and the UANs, new contract with the VA will have a dependent care provision. The need is not just for childcare and elder care, but also for special cases such as disabled spouses. Appropriate facilities should be made available, although the question of how they get staffed is probably beyond the purview of the Commission. VA may also need new authority to provide a safe place to bring dependents.

Somehow, the functional needs always seem to exceed what's available, even if a facility has just been built or upgraded. His hope is that as the Commission puts together its recommendations, it will look carefully at more than just the number of veterans that VA plans to be treating. He hopes it will look at accommodating the needs of the workers.

Q&A/Discussion

In response to questions about the job losses that have resulted from consolidations in the last ten years, Ms. Lee said the losses haven't been large. Her organization's real concern is to have the work be done by people who care rather than by private contractors who don't understand veterans' issues or the VA system. Mr. Boucher said he represents people in three of the facilities that were affected by CARES 1 -- the VISN12 Pilot Program. In at least one of the facilities, the employees he represents are being required to re-apply for their jobs, including employees who have been there for 15 or 20 years. So the consolidation has created an oversupply in one area and the people are now faced with the prospect of losing their jobs. This indicates that the potential for job loss exists. He also said that acute care nurses may well resist moving to an outpatient care environment and, in many cases, will probably look for another employer rather than re-train.

A Commissioner asked the union representatives to elaborate on the amount of input that their local representatives had in the CARES planning process and whether it was an improvement over what happened during the Network 12 pilot. Mr. Boucher said that 75 percent of the units he represents have said that they are at least at the table where CARES discussions are being held. There have been a couple of places where the participation has been inadequate. When faced with possible fallout, these people probably wish they had been more involved. He personally had a lot of input at the

facility level, less at the VISN level. He feels that overall his representatives are satisfied with their involvement, although it could have been both better and earlier in some cases. Ms. Lee stated that where the relationships are good, the participation has been good. However, overall participation has not been extensive (at the 90 percent level, for example), but rather, in some VISN's it has been at 50-60 percent.

Stakeholder Presentations By:
Bob Wallace, Executive Director, Veterans of Foreign Wars
Bill Bradshaw, Director of National Veterans Services, VFW

Mr. Wallace said that VFW is very supportive of the CARES process as long as it improves the VA health care system. VFW recognizes that VA has some outdated facilities -- some that may have been good 50 years ago but are not adequate for today's medicine and others that are not necessary and should be taken away. However, if the facilities are taken away, the health care shouldn't be taken away.

Mr. Wallace said VA has done an excellent job in getting out to communities through CBOCs, which are a step in the right direction. He also said once veterans get into the system, there are very few complaints about the quality of care that they receive. The problem veterans have is with the long wait to get into the system, but once they are there they are very happy and very content. CARES must not be perceived as pushing any veteran out of the system. He said when veterans are going to lose their facility or have something done with it or have the mission changed, they need to understand that VA is not disenfranchising any veteran. Mr. Wallace said that's where the tough part is going to come -- preaching the gospel to the local community so they understand what's going on.

He said VFW has some concerns about the actuarial model that was used by Milliman. It may not reflect the true patient mix of specialized care that the VA has. VFW people on the local staff are trying to work through the CARES data with this in mind.

VFW is also concerned about long-term care. Long-term care needs to be looked at very carefully. In reviewing some of the VISN Planning Initiatives, VFW became very concerned that long-term care, nursing home care, domiciliary care and mental health services are not part of the plan. It was told they would be incorporated in the future. VFW doesn't understand why these weren't included in the process from the beginning and is concerned that they will have to be handled as "add-ons." Mr. Wallace said he also doesn't understand how the Commission will be able to do its work without all of the data. He further noted that VFW doesn't understand what's going on with the data for these programs. Their discussions with VA officials have only yielded assurances that they are "working on it" and that is bothersome to the VFW.

VFW thinks the Commission will have a very interesting time with its field hearings (which Mr. Wallace characterized as "town hall" meetings). He said the Commission should realize that local Veteran Service Organization (VSO) people are going to be whipped up by VA employees who think they're going to lose their jobs. He believes the

same is true for the universities. VFW witnessed this in Chicago with Northwestern University pumping up local VFW people and staff. the local people may not understand what's really going on as they may think they are losing something. Hopefully the local VA people will be communicating at the local level in some effective way but this may not be happening. In one area Mr. Wallace visited, the local VA people claimed they were conducting outreach using the Internet. The problem with that is that many of the people who use VA may not have Internet access. Realistically, VA can't expect to reach everybody, but it can try to do the right thing.

Mr. Wallace said VFW's view is that the only people who can make CARES fail are VA employees. If VA management is not honest and forthright with the constituency, if they don't tell people what's really going on and then they are the ones who will make it fail. There have been a couple of instances so far where people weren't honest and forthcoming about what's going on, but he hopes that won't happen too much. If VA will explain to people what's going on in an open manner, there shouldn't be any problem. If they don't communicate properly and people find out what's going on by reading a Planning Initiative resolution, CARES will be in trouble. This happened recently in Network 3 where a person who sat in on 22 planning meetings was taken completely by surprise when the VISN plan included a solution that hadn't been talked about. It turned out to be one of the required alternatives, but the VFW representative had not realized such a requirement existed.

VFW also is concerned about the level of coordination and communication with DoD. Base Realignment and Closure (BRAC) of military institutions is still being implemented and there are some places where the two agencies should use better cooperation. There should be some conversations about this at the local level, but the VFW isn't sure there is enough momentum at the local level to overcome the DoD/VA communication barriers. Mr. Wallace repeated that VFW wants CARES to work.

Mr. Wallace stated VFW and other organizations had been under the impression that money from the sale of VA facilities would go back to the VA for use in enhancing facilities. Now they are told that the money might have to go back to the Treasury. That decision is creating a large concern. One of the reasons why VFW was so supportive of the whole process was because the original idea offered a way to expand needed facilities and programs where needed. Legislation may be needed to ensure that monies realized from selling any VA properties would go back to the VA for enhancement of health care.

Q&A/Discussion

A Commissioner indicated that there seems to be a degree of confusion surrounding what VA may or may not be able to do with any money realized from the sale of VA facilities. In VISN 12, for example, VA was allowed to keep the money realized from disposing of the Lakeside property and reinvest it in new facilities. He concluded that the matter of reinvestment may be an open question.

When asked, Mr. Wallace indicated that there is a lack of communications at the National level and a local level. He said he wants to be very clear that VFW does not want to run the VA system. It doesn't expect to know everything that's going on behind closed doors. But the VFW does expect that when VA is going to do something that will impact veterans' health care, VA will tell the VFW *before the fact* not after the fact.

Asked for more detail about VFW's concerns about the actuarial model, Mr. Wallace said the main concern is that it doesn't include all specialty care, so it doesn't have mental health issues, long-term care or other specialty care programs.

One commissioner said the challenge, both for VA and organizations such as the VFW, will be to minimize the negative reactions and to recognize that it will not be possible to make changes without somebody's "ox being gored." He hopes that VFW will use its influence to recognize that the greater good will be served when the process is completed even though there will be inequities. Mr. Wallace responded that he understands the point. For example, in VISN 12, the local people were all whipped up about what was happening. After several meetings, the national organization asked for a letter outlining the problems. The bottom line was that the people who were upset didn't want to go to West Side for treatment. The VFW sent a letter to VA, which took care of the issue.

Mr. Wallace said that the VFW field directors will be at every one of the Commission's public hearings. They will have people all over the country that will be trying to bring a common understanding to the hearings, but the National organization won't be whipping them up. He agreed with a Commissioner that one of the problems in the Pilot program was that management, not rank and file employees, was putting out bad information because they were not involved in the process, which was being handled by a consultant. Now, VA managers are driving the process. He would hope there would be less bad information given out because of management's involvement.

A Commissioner asked Mr. Wallace to encourage the local affiliates to join the Commission for its hearings. The Chairman agreed, but emphasized that the field hearings would not be "town hall" meetings -- they will be formal hearings.

A Commissioner commented that the major area of concern is the data that's missing and that he trusts that the Department can and will expand and improve the data. Another commented that his concern is that there needs to be something in this process for the employees.

Mr. Wallace stressed that VFW is not tied to physical structure. Instead it is tied to providing quality health care for veterans. Asked about the organization's historic building preservation resolution, he agreed it might present a barrier and agreed to work with the Commission on this issue.

Presentation By:
John Sommer, Jr., Executive Director, The American Legion

Mr. Sommer said as far as The American Legion is concerned the VA has a quality health care system, but it is obviously a system that needs some help. One of the Legion's concerns is that there are too many people waiting for health care. Numbers vary -- he has heard estimates of between 260,00 and 300,00 people on the wait list -- but the waiting times for care at VA facilities are six months to a year.

The American Legion is concerned about long-term care and the way that it's being handled within the CARES system at this time. He stated that the majority of long-term care provisions have gone out the door. He emphasized veterans need this type of care along with related care for Alzheimer's and dementia, but it is diminishing within the system.

The Legion is concerned about the much smaller number of patients with post-traumatic stress disorder who are in the system now. As more was learned about post-traumatic stress disorder in the eighties and nineties, there were 18 inpatient PTSD units in the system around the country at the highest point. He stated that now there aren't more than a couple operating. He also stated it has been decided that equivalent quality care can be provided on an outpatient basis. That was decision was made on the basis of one study and as far as The Legion is concerned, the decision should not be made on the basis of a single study.

The American Legion has a similar concern about the loss of substance abuse treatment programs as soon as the VERA was initiated. The justification was that the program was too expensive. The Legion doesn't believe decisions should be made about whether or not to treat veterans on the basis of whether the program is too expensive.

The National Commander, Ron Conway, has taken the VA health care system very seriously for a number of years. He is in the process of visiting at least one VA hospital in each state during his year as Commander. In most cases he has visited more than one facility. Moreover, the visit is not a "photo opportunity;" it is a visit with the director and senior staff during which a series of questions are asked to learn where problems exist. He then compiles a report on the facility and also asks the management to complete a survey form so that The Legion will have consistent figures from each facility.

Because of the large waiting list of veterans across the country, The Legion initiated a program called "I AM NOT A NUMBER." Under this program the Legion is surveying many of the veterans on the waiting list to find out what their problems have been, why they have had to wait as long as they have to be treated and what has happened to them during the period of time they have been waiting. The Legion is going to compile the information from the Commander's report and survey and issue a final report at the end of June or early July. The report, which will be provided to the Congress, to the VA and to the Commission, will show what the Legion has found over the past year, identifying both the problems and the good things that are occurring within the VA health care system.

The American Legion, the Veterans of Foreign Wars and the Disabled American Veterans have joined forces to work for the enactment of legislation related to mandatory funding for VA health care. He stated the three organizations have always worked together, but this time they signed an agreement. All three organizations believe that mandatory funding is the only way that VA health care will really be funded to the extent and way it needs to be.

The Legion is concerned about the President's budget proposals for 2004 and the elimination of priority level eight veterans. Unfortunately, many people think that "priority eights" are high-income veterans. The actual income limitations show that this is not true. There may be some high-income veterans in the group, but for the most part these individuals could bring their own income stream through third-party reimbursement of the VA. The result of eliminating the enrollment of those veterans eliminates third-party income from coming into the VA system.

The Legion is also opposed to the \$250 enrollment fee. There are some veterans for whom it would be very difficult to pay \$250 to enroll in the VA system.

With respect to the CARES Phase II process, Mr. Sommer said the American Legion supports the process and its stated goals. The Legion has had concerns since the program began about what happened in the Chicago area (VISN 12, Phase I) but recognizes that a lot of changes have been made in the process. In particular, the VA has promised a great deal more transparency in the way operations take place and more stakeholder involvement. The American Legion has someone in each network working with the VISNs on the plans they are designing. The Legion is getting reports of varying degrees of cooperation, varying degrees of transparency and varying degrees of input. So far there have been no reports of major problems -- of not being included. There have been several reports from representatives to the effect that there haven't yet been meetings where stakeholders were invited to take a look at the development of the market plan. Others have said they have been involved in every step. The Legion's concern is that they don't want their involvement to be in the form of a briefing on what's taken place. It wants to have input into the development of the market plans as they are being designed.

The Legion has also established a Facility Assessment Advisory Committee. The market plan is based on data. But the Legion remembers that this whole process got started when the GAO said the VA was spending \$1 million a day to support buildings that weren't being used. So the Legion assembled a group of individuals who have backgrounds in engineering and architecture who will see whether they can offer some input.

The Legion is also concerned about some of the comments it has heard from people in the VISNs who are involved in the development of the plans that will be coming to the Commission. These comments concern such matters as a GAO person showing up at one VISN asking what they are ready to sell. Legion people have also been told that the CARES process is a top-down process that is being mandated from Washington rather than a bottom-up process where the information is being developed at the local level.

The Legion will be keeping an eye of these things and is very interested in the work the Commission will be doing.

Q&A/Discussion

In response to Commission inquiries about the availability of the Commander's field reports, the Legion's veterans' survey, the findings of the Facilities Assessment Committee and the legislative proposal, Mr. Sommer agreed to share the Commander's field reports with the Commission, although he stressed that these are not produced annually for every facility. The survey findings, which will be nationwide but broken down by facility, will be available the end of June or early July and Mr. Sommer will provide copies to the Commission. The Facilities Assessment Committee has just been formed, so nothing is available yet. Legislatively, the Legion is supporting Chris Smith's bill; it hasn't drafted its own bill. Right now it is focusing on getting support for the philosophy of mandatory funding. He also agreed to provide the Commission with copies of the Legion's monthly magazine.

A Commissioner noted that everybody has concerns about long-term care and psychiatric care, and nobody seems to know the answer. He said the Commission would take a look at those concerns. Mr. Sommer said there obviously is a problem; years ago long-term care was readily available in a number of different forms, including nursing homes and domiciliaries. That availability has steadily eroded as time has gone by and now we are looking at only a six-month contract in a community nursing home. He understands Dr. Roswell is looking at providing more home care, but that doesn't always work either, particularly with elderly people. It is a big concern and the Legion is pleased that the Commission is looking at it.

A Commissioner said the result of the CARES process won't be perfect -- there will be areas that need work. He said the Commission would need the Legion's help. The Commission doesn't want a few disgruntled people to sink the whole thing and wants to avoid a groundswell of discontent. He hopes the Legion will make an effort to help its members get over the "speed bumps" in the process. In response, Mr. Sommer agreed that some positive changes would be proposed. The Legion supports the goals of the process and he expects it to agree with a lot of the proposed changes put forth in market plans. He also said the plan may well include things that the Legion opposes. While the Legion won't try to sell those to its members, it also won't try to kill the whole thing just because they oppose a few things. The Legion will cooperate to the extent it can.

A Commissioner observed that the CARES process required the VISNs to get stakeholder input. He is beginning to sense that full interaction is not occurring and asked Mr. Sommer to comment on that. Mr. Sommer said it has varied from one VISN to another. Some representatives have said there have been numerous meetings and they have been fully involved; in other cases the representatives have said they haven't yet had any meetings. Asked whether The Legion had given feedback to management about the lack of meetings, Mr. Sommer said he interacts with the CARES Office regularly.

Asked how often The Legion prepares site visit reports, Mr. Sommer said it varies for several reasons. One is that The Legion changed its procedure and in order to do that The Legion considerably slowed down the process for a period of time. Additionally, The Legion has had staff turnover and is training new people. During the training period, there are three people going to one VISN instead of three different VISNs.

In response to a Commissioner's question, Mr. Sommer indicated that the Legion will attempt to have someone at each of the Commission's hearings.

Presentation By Commission Staff Review of CARES Planning Initiatives

Mr. Larson introduced a staff review of the CARES gaps and Planning Initiatives. The proposed solutions to the PIs will be the focus of the Commission's hearings. The staff review was conducted for two main reasons. One was to validate the National CARES Planning Office's implementation -- did they reasonably adhere to the uniform application of the data when establishing the PIs? This afternoon, staff will be discussing their review with the Commission teams. At the May meeting, the Commissioners will be asked to make a decision on the question of uniform application. The second reason to review the PIs is that it is the beginning of the process of acquiring an understanding of the issues on the ground by both staff and Commissioners. When the Commission goes into the field to conduct hearings, these hearings will be about solutions -- proposals -- directly related to the gap -- the problem -- that is embodied in the PI. The first step is to understand the problem. The next step is to understand the solution. The third step is to conduct hearings and get input from a wide variety of sources.

Mr. Larson asked the Commission for feedback on the staff work, noting that this is the first time the staff is presenting original work to the Commission. The mission of the staff is to support the Commission; it wants to do the best possible job. At the end of the session today, he asked that the Commission tell the staff what they did well and what could have been done better.

In response to a Commission question, Mr. Larson explained that the session would focus on the gaps. The gaps were identified by the NCPO. They were data driven, based on the model, and became the basis for identifying Planning Initiatives (not all gaps were selected for Planning Initiatives). The Planning Initiatives, in turn, will result in market plans that will propose solutions to the gaps.

Mr. Larson stressed that the reviews were not a collaborative effort -- each staff team reviewed the data for the VISNs for which they are responsible. The work was done under the general leadership of one of the staff who had experience working with CARES in the field.

Asked whether anybody had actually validated the data used in the model, Mr. Larson said that the two experts who are working on the model may do that as part of their job. But for this afternoon's presentation, the answer is "no."

Staff referred the Commission to Tabs 8 and 9 of the meeting binder (Planning Initiatives Overview and Team Planning Initiatives by VISN) for the three-part presentation. The first part is to identify the data and references that were used. The second part will be to look at the number of PIs identified. The third part will be to look at the findings.

Staff outlined the analytical process that the staff used to review what NCPO did. First the staff defined the policy or standard that NCPO used in the gap analysis to develop the PIs.

The analysis asked four standard questions:

- How were the PIs identified?
- How were exceptions identified and what were they?
- Were exceptions handled as required by the CARES guidebook?
- Were PIs reviewed by stakeholders and the VISNs?

A task list was developed to use as an algorithm for answering the questions. Staff emphasized that the staff didn't get into the solutions, only the gaps. They looked for and identified discrepancies in the data.

Specific tasks included:

1. Validating the 77 markets, i.e. verifying that NCPO used the same 77 markets throughout the process (the answer is "yes").
2. Validating the extent to which PIs and non-PIs are supported by data and/or the NCPO process (whether or not the results were consistent and reasonable is a decision for the Commission).
3. Identifying exceptions to the selection/non-selection criteria (the main focus of the analysis).
4. Reviewing all PIs for documentation indicating that stakeholders were briefed on the final selection.
5. Commission review to identify information needed for PIs that aren't clear.

For this session, the staff teams concentrated on task number three above -- identifying exceptions to the pre-determined selection criteria. Exceptions were of two types: (1) gaps that met the criteria for selection but were not selected as PIs by NCPO; and (2) gaps that did not meet the criteria for selection as PIs but which were selected by NCPO.

Staff displayed a chart showing all 351 gaps in the CARES process by VISN and by CARES categories, noting that the 351 gaps are distributed reasonably evenly among the Commission's teams. VISN 1 was used as an example to describe the scorecard the staff used to assess the PIs, and where staff's "findings" were highlighted.

One individual from each Commission team then demonstrated the analytical process using a sample VISN. The purpose was to familiarize the Commissioners with the review process and the information to be used by the teams later in the day .

Staff summarized the results of the staff analysis using VISN 16 (Arkansas, Mississippi, Louisiana and Oklahoma) as an example. After presenting an overview of the VISN (number of markets, number of enrollees, location of medical centers), she summarized the Planning Initiatives in the VISN by CARES categories (capacity, proximity, small facility and other). Exceptions were identified and described in terms of either (1) chosen but didn't meet the criteria, or (2) met the criteria but not chosen. An "of note" category was also used to highlight other items the staff thought the Commission may be interested in.

For VISN 16, Staff's VISN highlights included: four markets, a six percent increase in enrollment projected for 2022 and the identification of 22 Planning Initiatives (PIs). Gaps related to *capacity* in this VISN include a lack of inpatient and outpatient services in the Florida panhandle (which has a large and growing population) and PIs for a new spinal cord injury unit and blind rehab center. VISN 16 has one gap related to *proximity* - 4 VA Medical Centers within the 60-mile standard in Jackson, New Orleans, Gulfport and Biloxi. one *small facility* gap in Muskogee, Oklahoma. In addition, the VISN has a PI related to its 213,000 square feet of vacant space and has identified a number of collaborative opportunities. "Of note" items were a decrease in surgical inpatient beds in the central lower market.

Exceptions identified during the analytical process for this VISN included:

1. Three "not chosen but met" gaps (i.e. conditions that met the pre-determined criteria for selection as a PI but which were not selected by NCPO):
 - Outpatient mental health gaps in three markets;
 - In patient surgery gaps in two markets; and
 - Inpatient psychiatry in one market.
2. One "chosen but not met" gap (planning initiatives that were identified by NCPO but which did not meet the pre-determined criteria):
 - In patient surgery in the central lower market.

One Commissioner pointed out that this VISN is an example of the problem where one group of veterans -- those requiring mental health and psychiatric care -- will apparently lose their place in line for more resources due to inadequacies in the model and in the selection process.

Another Commissioner asked what the justification was for selecting PIs where no gap had been identified. Staff replied that had not yet been documented. If the Commission chooses to act on the exceptions, staff will try to get additional information about these "exception" cases. This question will be taken up in the team meetings and brought back to the Commission for a decision.

Staff repeated the above process, using VISN 3 (New York City and New Jersey. In this VISN, three markets were identified (Long Island, metro New York and New Jersey). Overall, the VISN is projecting a 38 percent decrease in enrollment over the planning period.

The VISN has 16 identified planning initiatives plus a possible spinal cord bed relocation. It is a real "prize winner" in the vacant space category with over 1 million square feet. Three of its fifteen sites have the potential for enhanced use.

VISN 3 has 2 *proximity* gaps:

- One resulting from seven VAMCs within a 60 miles radius, and
- One resulting from five tertiary care facilities within a 120-mile radius.

Staff noted that locally-heavy traffic in the New York-New Jersey area increases the driving time involved in traveling to these facilities. Consequently, the VISN has only one proximity planning initiative instead of two.

The New York-New Jersey VISN has one *small facility* -- at Castle Point. Projected beds are ten in 2012 and thirteen in 2022.

Conditions "of note" in the VISN include:

- A projected decrease in the number of medical beds in metropolitan New York in 2022 (although an increase is projected for 2012).
- A similar situation in metropolitan New York for psychiatry beds.
- A projected decrease in the number of surgery beds in metropolitan New York in both 2012 and 2022.

In terms of exceptions, the VISN had no "criteria met but not chosen" gaps. It did have one "chosen but not met" gap -- an increase in medical beds for 2012.

In response to a question from a Commissioner about enhanced use, staff said the program results from special statutory authority that allows VA space to be used by the private sector under contract. A follow-up question asked if the authority allows the facility to keep the money. Discussion among the staff and the Commission developed the following points:

- The facility can lease space for uses related to VA's mission and keep the rent money it earns. It can also rent space to make money until the VA has other uses of the facility. But it can't rent space permanently for the purpose of making money (land for a hamburger stand, for example).
- The implication of the enhanced use program is that it will be used to improve VA space for an application related to what VA does -- for a doctor's office for example. It can also be used for joint projects, such as an assisted living facility.
- Legislation to authorize VA to keep the money from the sale of its facilities is working its way through Congress. The leasing process is slow and cumbersome and also requires Congressional review. It needs to be streamlined.

Another Commissioner noted that the Veterans Benefit Administration has proposed moving its office into the Medical Center. He asked if things like this are sent to the VISNs for review. staff replied that they are.

Staff provided the Commission an overview of the markets in VISN 1 -- New England. This VISN has four markets, which he outlined geographically. It is projecting a

seventeen percent decrease in enrollment VISN-wide by 2022. It has twenty Planning Initiatives.

Its *capacity* gaps include access to primary care in one market and access to hospital care in two markets. It has no *small facility* gaps. *Proximity gaps* include:

- Four VAMCs within a 60-mile radius in one location (which was selected as a Planning Initiative) and
- Two VAMCs that met the selection criteria for tertiary care proximity (which were not selected because of locally heavy traffic conditions). Moreover, these two centers -- West Haven and Bronx -- crossed VISN borders.

"Other" conditions included:

- 488,300 square feet of vacant space, and
- VISN-wide construction and infrastructure issues.

The staff identified one "met but not chosen" exception -- inpatient psychiatry in the far north market -- and two "chosen but did not meet" exceptions. These were (1) inpatient psychiatry in the east market, and (2) outpatient primary care in the west market.

Staff, in summary remarks about the overall PI review process, said that three themes emerged as being "odd" to the process:

- The earlier emphasis on sub-markets seems to be disappearing.
- There are inconsistencies in how the gaps were selected for PIs.
- The selection of mental health PIs identifies inconsistencies in how these gaps were handled.

Q&A/Discussion

Commission questions included several definitional clarifications, including (1) the difference between a "gap," a "planning initiative" and a "market plan;" and (2) the difference between "access" and "proximity."

Several Commissioners also expressed an interest in how well VISNs had done in obtaining stakeholder input and in explaining and justifying exceptions and whether potentially controversial PIs had been discussed with the VISNs before being sent out.

Commission Team Meetings

After the overall presentations highlighted above, the three Commission Teams met in individual breakout sessions to review the staff analysis and discuss inconsistencies and anomalies in the CARES Planning Initiatives. Each team reviewed the staff analyses for its assigned VISNs. Staff members presented an overview of each VISN and described its Planning Initiatives by CARES category and market area following the model used in the introductory presentations (above). Staff then presented their analyses, discussing it with the Team Commissioners and highlighting certain exceptions. Commissioners

commented on the analyses, asked questions and gave guidance to the staff regarding further information gathering.

Commission Discussion of Team Findings

Reconvening, the Commission heard reports from the Commission Team Leaders and provided feedback to the staff concerning the analyses. Comments and requests included:

- Compliments to the staff for the useful analytical work.
- A request for more time in individual team sessions.
- A request for an executive summary of the justifications for proposals.
- A request for more narrative material.
- A request for a list of unaffiliated VA sites.
- More information about the mental health issue.

Mr. Larson noted that some of the information requests appear to conflict, but said that the staff supporting each team would develop materials tailored to its team's needs. He also said he thinks that a definition of "reasonable" will begin to emerge after the first week of hearings.

Yet to be addressed is the matter of sharing information, analysis and findings between teams as the hearings progress where that is necessary and desirable (in identifying regional issues, for example). The staff will be addressing that issue as part of the hearing plan.

Mr. Larson also agreed to have someone from the Under Secretary's Mental Health Group address the May Meeting and provide the Commission with more information on the issues.

Friday, April 4, 2003

The Chairman summarized the agenda for the day, which is to hear from additional stakeholders and from the Deputy Secretary.

Presentation By:
Joe Ilem, Assistant National Legislative Director
Disabled American Veterans

Mr. Ilem said CARES, including the work of the Commission, is a very important process to the DAV. Ten years ago, most member correspondence was about the quality of VA health care. Today, that is no longer the case. VA is providing quality health care and veterans are satisfied with the care they are receiving. Today veterans are concerned about *access* to VA health care -- getting into the system in a timely fashion. Access has been very difficult for many veterans around the country. The Commission will be

dealing with plans for the future of VA that will shape that access and determine how veterans will be able to get into the system in a more timely fashion than occurs today.

The DAV supports CARES. It realizes that the re-evaluation of VA capital assets is necessary given the changes in VA health care over the last five or six years. In 1996, Congress passed eligibility reform, which opened the VA to all veterans. Not all veterans are using the system, but there are roughly seven million veterans who have enrolled and about four and a half million users of the system.

Mr. Liam confirmed that DAV, along with other veterans' organizations, is supporting mandatory funding legislation for VA health care. He believes it is possible that mandatory funding will be enacted. If so, it will help to shape the future of VA. Mandatory funding is embodied in Senate bill S.50, introduced by Senator Johnson. Senator Daschle also has introduced S.19, which is the leadership bill that contains provisions for mandatory funding. Both of these bills are modeled on last year's bill introduced by Chairman Smith and ranking Democrat Lane Evans of the House Veterans Affairs Committee (which has not been re-introduced yet). What the bill does is take the obligated 2003 appropriation and multiply it by 120 percent to provide VA's funding for 2005. After that, appropriations would be made on a per capita basis based on the number of veterans enrolled and the appropriations VA receives. That amount would be increased each year by a cost-of-living adjustment (COLA). VA would then know, based on their enrollment as of July 1, how much money it would be receiving on October 1. as a result, there would not be a delay in receiving this money so the bill will solve a lot of VA's problems. This year, it took VA five months to get its budget for discretionary appropriations. That can't be allowed to happen again because it makes it very difficult to manage a system. Mandatory funding would change that by taking out the uncertainty and replacing it with a formula for VA to determine what its funding would be. It would be an important factor in determining healthcare needs in the future.

He said VA's outreach to the VSOs has been good. The DAV's problem on a national level is that it *is* national. It has chapter representatives throughout the country who are personally affected by what is going on with the CARES process. In Chicago, those people are being properly advised what is going on in their location, so the national relies on them to let it know what's best for the Chicago area. One of the biggest problems for the national organization is trying to identify its members who are on some of those commissions at the local level. It's important for the national organization to know who the local people are dealing with at the local level so they can stay in touch.

The DAV has some concerns about the model, particularly with regard regards to special disabilities. DAV believes that further development of the data is needed prior to full consideration of mental health, long-term care and domiciliary care.

DAV also believes that the window of opportunity for analyzing the very extensive data that is being received from the field is too short. If the model fails to address the unmet needs for services, there will really be a problem in the future

The mandatory funding proposal includes all enrolled veterans, which is important from DAV's standpoint. VA has said it can keep the system functioning by caring for the core veterans in groups one through six for the next ten to fifteen years. The service men and women who are serving in Iraq now, many of whom are 19 years old, are going to need the VA well into this century. It is important that we have a system in place that provides the types of services veterans need -- blind rehab, spinal cord injury, post-traumatic stress disorder, prosthetics and amputations. These VA services must be available in the future. Using other approaches to providing health care will not result in veterans getting the services they need, especially when other health care systems experience skyrocketing costs in the future.

Q&A/Discussion

Mr. Ilem was asked to comment on how his organization feels about opening up the health care system to everybody. The Commissioner noted that DAV membership consists of veterans with service-connected injuries, whereas The Legion has a much broader charter. The Commissioner said he would expect the DAV's focus to be on the priority groups one through sixes. Right now, everybody has a hard time getting into the system. If you open the system to everybody, it seems like the priority groups one through six would have a harder time getting access to care. Mr. Ilem cited the example of a 100 percent disabled combat veteran who wasn't even able to enroll in the system that was supposed to be designed for his use. DAV does believe that service-connected veterans are key elements of the system. At the same time, as he pointed out earlier, VA is saying that it can keep the system running for 10-15 years just by taking care of the priority one through six groups. In order to ensure that this system will be available for the veterans who are now serving in Afghanistan and Iraq, we need to be able to care for all veterans who are sent to VA. That is the purpose of the mandatory funding bill. The problem is that there aren't enough resources available to the VA to ensure that all veterans receive timely care. We wouldn't need special priorities for service-connected veterans if VA had adequate resources to care for everyone in a timely manner.

He added that DAV is very concerned about the possible decision of not allowing the VA to keep the proceeds from selling its property. He said that would turn CARES into CAR -- there would be no enhanced services without the money to invest.

Asked whether DAV would oppose the CARES plan if it doesn't include specialty care, Mr. Ilem said DAV would have serious concerns if it weren't included, and would have doubts about how the Commission makes decisions. But he wouldn't say that DAV would oppose it.

Regarding input, he said DAV is getting mixed signals from local people and cautioned the Commission about the need to filter the information they receive -- local people have been told different things. VA needs to make sure that the local people dealing with the VA understand the ramifications of the information they are receiving. What makes the Commission's job difficult is that it doesn't know what was told to people at the local level. Sometimes the information at the local level may not be the correct information.

Asked about local DAV involvement in CARES and special issues to look for in the hearings, Mr. Ilem said involvement has been mixed, depending on individual location. In response to a Commissioner's question, Mr. Ilem said the DAV has contacted people in an effort to have someone at all of the Commission's hearings.

Presentation By:
John Bolinger, Deputy Executive Director, Paralyzed Veterans of America

Mr. Bolinger said CARES is very important to PVA and its members, all of whom have experienced traumatic spinal cord injury or a disease of the central nervous system. The PVA membership includes both service-connected veterans and non-service-connected veterans -- about half and half. Its members represent veterans from World War II as well as young men and women who are getting out of the service today. PVA's members from World War II represent a generation of people with spinal cord injury who are entering old age for the first time. This is a new challenge that will have to be addressed. About 44,000 veterans have spinal cord injuries; many more have neurological damage such as multiple sclerosis. Before World War II, people with spinal cord injuries didn't survive. Now, with antibiotics taking care of the secondary conditions associated with spinal cord injury, people survive and live longer lives, but they face new challenges. Sometime in the 1940's and 1950's people in wheelchairs were thrust on society. Similarly, society was thrust upon people in wheelchairs. PVA was chartered by Congress in 1971; it has 34 chapters across the country. Each chapter has a well-informed point of contact who is waiting for the Commission. Each wants to contribute meaningful input to its deliberations.

The mission of PVA is to promote quality health care for people with spinal cord injury and disease, to promote quality research and education, to ensure that members get the government benefits that they legally deserve and to advocate for civil rights and opportunities to maximize independence.

He emphasized that PVA members -- veterans with SCI -- use the VA system in their daily lives. They need supplies, prosthetics, counseling and recreational, occupational and physical therapy. VA services are absolutely critical to enable them to function on a daily basis. They have a stake in CARES and care deeply about the result.

The VA has 23 spinal cord injury centers across the country and 62 spinal cord injury clinics. Looking at a map will show that PVA members and others with spinal cord injury are clustered around those centers of excellence and SCI clinics. Many of them return to the SCI Center where they were first treated.

CARES planning is being done on a VISN by VISN basis, with each plan focusing on the needs of the veterans who are in that particular VISN. But the VA's SCI system really doesn't have distinct boundaries or catchment areas. Veterans will travel many miles to get the care they want and there is a lot of crossover.

VA must be prepared to address the aging of veterans with SCI. These challenges are often difficult. Long-term care is a critical component of the continuum of care that VA offers to paralyzed veterans. Long-term care beds are needed and must be included in the spinal cord injury mix.

SCI care groupings must include access to spinal cord injury centers of excellence. Moreover, PVA feels very strongly that spinal cord injury care must continue to be associated with and a part of tertiary care centers. PVA is concerned that changes might result in moving the components SCI patients need. People with spinal cord injury must have ready access to all of the things they need in a tertiary care setting.

PVA believes that it's important to understand that SCI centers must have a certain critical mass. New facilities must be thought about in terms of being attached to a tertiary care center that has sufficient nursing and staffing to provide for multidisciplinary needs.

PVA encourages its members not to use CBOCs. At the very least, its members should proceed with great caution. Their experience has been that CBOCs are often not accessible to people who use wheel chairs and that some of the care is not appropriate to the multi-disciplinary nature of spinal cord medicine. He asked the Commission to consider this situation.

PVA supports enhanced use leasing and warrants innovative thinking in the context of long-term care.

In closing, Mr. Bolinger offered PVA help to the Commission in understanding the demographics and models associated with SCI.

Q&A/Discussion

In answer to a Commissioner's question about whether PVA is having any luck in working with VA on enhanced use ideas, Mr. Bolinger said PVA has been involved with several proposals over the past couple of years now PVA is interested in a New Mexico proposal but there is some kind of hold on the process. He believes there is a lot of merit in moving forward with the program in such areas as assisted living and long-term care.

Mr. Bolinger was asked to elaborate on the SCI model and whether it is a document the Commission might obtain. He indicated that the SCI model was submitted to the CARES group in Washington. It was then incorporated into the larger model.

In response to a Commissioner's question, Mr. Bolinger said he would be happy to share PVA site survey reports with the Commission. The survey team, consisting of several doctors, visiting all spinal cord centers at least once every 24 months.

PVA will have representatives at all Commission hearings. He hopes that PVA will be able to analyze the plans before the hearings and provide specific information regarding the proposals, but the time limits are a severe constraint.

Responding to a Commissioner's question, Mr. Bolinger said there has long been a memorandum of understanding between DoD and VA about how returning servicemembers with SCI receive care. The agreement has always been to get them to an acute spinal cord facility as soon as possible. To do otherwise would be a disservice. He agrees that DoD should not send active duty servicemembers to civilian hospitals by when they return home from the Gulf.

He said part of PVA's opposition to CBOCs is that it wants people with chronic disability conditions subjected to a clinical assessment before being moved to the end of the line for administrative reasons (such as income level or lack of service connection). SCI individuals need to be treated by an appropriate specialist who understands the complexities of spinal cord injuries, or be referred to one. If the CBOCs would implement good, formal referral protocols, PVA wouldn't be so concerned.

A Commissioner commented that VA used to have an SCI training program in every outpatient clinic and at all centers. However, it hasn't been maintained and as people rotated out of the program, the training became diluted. There also used to be an SCI coordinated program within every medical center. But it's not mandated and its is within the discretion of the individual VA medical center as to whether they implement it.

Mr. Bolinger closed by adding that VA is a "champion" at research; VA research has been responsible for many advances.

Presentation By:

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

Mr. Weidman said his comments start with the premise that the VA system is, or should be, a veterans health care system, too often, it is not. He gave out a card containing part of the 1982 M1-A1 Manual, which is supposed to be the veterans' assessment guideline of VHA. Since 1982, the Manual has required that every single veteran who comes to the VA hospital first have his military history taken. If he served in a dangerous military occupation, being on a carrier deck, for example, or if he served in a combat theater of operations, the individual is also supposed to be given a full psychological-social work-up. Mr. Weidman stated that the workups do not happen, which leads right into CARES.

The Vietnam Veterans of America (VVA), from the National President Ron Corey down, believes the concept behind CARES is correct -- VA should not be spending taxpayer dollars on refurbishing facilities that will no longer be used in the future, or building facilities only to have them abandoned in a few years. There are too many other system-wide needs. For too long, the VA, pressured by OMB and others, has taken the short-term approach as opposed to a long-term view. The result is poor stewardship of

VA's physical plant. The result is there are facilities that are grossly inefficient and expensive to maintain and that don't provide the services needed.

The CARES process started long before any of the Veterans Service Organizations got involved. When the VISN 12 project under Booz-Allen became a pilot, VVA raised the issue that the wounds of war and the wounds of veterans are different from those of the average citizens of the United States. The way to think about VA is "occupational health." All vets, whether they served for two years or twenty-five were engaged in a very dangerous occupation. Defending our Nation is a dangerous business that involves activities with dangerous equipment. The conditions in the military probably wouldn't be tolerated in any civilian population. The problem with the formula used now, is that it does not take into account the differences in civilian medicine and veterans health care. It does not take into account, for example, spinal cord injuries or the long-term effects of toxic slam. That's one problem.

The other is that civilian medical systems work on the basis of one to three presentations a year from people seeking health care. That's not true for VA, where the average is five to seven presentations. It's not unusual to have individuals with twelve to fourteen presentations. This makes an enormous difference in the amount and variety of resources that one needs to have in order to address that individual's problem.

The job of VA health care is, insofar as possible to make that individual whole again. There is an implied contract. These individuals step forward in defense of the Constitution of the United States; they are risking life and limb. In return, the people of the U.S. have a responsibility and an obligation to make them as whole again as possible: physiologically, psychologically and economically. The first two are the responsibility of Government. The last is the responsibility of the community as a whole. War hurts people. Once you have served, you are never the same again. The young people who went into battle in the last few weeks, whether they were hit with hostile fire or experienced toxic slams or not, will never be the same ever again. War will have an impact on their physiological well-being and we need to be cognizant of that in the CARES planning process.

The country owe these people more than blood money. The position of VVA is that every single veteran's program, whether at National or state level, should be measured against the litmus test of making that person independent and as whole as possible. That means getting people back to work. To put it more bluntly, to help veterans become taxpayers again. That means the individual is functioning in the society again with some assistance from the VA.

VVA recommends that the Commission should ask veterans in the field whether they have seen the card (which he distributed earlier). Many people working in the system are not using it, including affiliates. These are basic questions that should be asked of every veteran. The first thing physicians are taught in medical school is "listen to your patient." Ninety percent of a diagnosis comes from asking the right questions. They don't ask the right questions because they don't know -- they haven't been taught what to ask. We

haven't given them access to knowledge about the very dangerous occupations that veterans practiced at one point in their lives. For example, 79 percent of veterans who served on the ground in Vietnam carry tropical parasites in their body that can remain dormant for over 50 years. Tropical medicine specialists know this from dealing with veterans who served in Burma during the 1940's. But many veterans who show up with symptoms that are diagnosed as other diseases, such as chronic acute depression. VA is treating hundreds of thousands of veterans for chronic acute depression. If these individuals are actually infested with one of the parasites, they will not get better. IF the right questions are not asked up front VA is not spending its money wisely. In VA, success is measured by the number of acute visits per year, not by how well VA is doing in getting veterans fully healthy and functioning in society again.

Another major issue for VVA is how many individuals are not using the VA hospitals because there are no services available for what is bothering them. The problem with the model is that it begins with what *is*, not *what's needed*. What is in terms of services and not what the need is in the veterans' community. Mental health is an example. Mental health care has been diminishing since the decision was made to use a new resource allocation methodology in the early '80s. There was an arbitrary decision to discount mental health beds by 17 percent. The consequence is that mental health veterans are on the street. The VA's SCMI Committee had a debate a few years ago about whether there was a decreasing need for a substance abuse initiative, but those who said veterans don't need those services, came to this opinion only after those services did not exist at many facilities because of cutbacks. For the CARES program, PVA had to send people out to physically review the findings that the SCI Units around the country had sent in to make sure they were accurate.

VVA has also commented on problems not within the Commission's purview. These include the lack of a financial tracking system and an adequate information system so the Secretary and others can have reliable real-time information regarding how many people are working on spinal cord injuries. With technological capability present, VVA seeks improvement in these areas

VVA also is concerned that specialized services, such as spinal cord injury, not be made an add-on to CARES. VA's mission is to have *veterans'* health care and not general health care that happens to be for veterans. As long as VA is trying to provide general health care, its going to have people coming back for acute care visits at the hospitals. If VA will address their problems in a holistic way, they wouldn't have to keep coming back for the very expensive acute care visits. Oftentimes, the information the patients will bring forth if asked the right questions is not the presentation that is driving those acute visits. Other things that are missed are often going on that cause the veteran to present himself at a VA facility. The system isn't set up in a correct manner to address these issues.

VVA also hopes the Commission will ask at hearings whether there is regular and substantive interaction between the veteran community and the VISN leadership. All 21 VISNs have management advisory councils, at least in name. They have an annual

meeting but without meaningful consultation with the stakeholders. VA needs to make contact with veterans in a meaningful way at the service delivery point so that people can be more knowledgeable. Interaction should be occurring at the local hospital level, not just VISN-wide. VVA believes it should be a requirement to have at least quarterly meetings at the hospital with the hospital director and chief of staff. Veterans need to have input at the local level.

Finally, VVA suggests that the Commission ask about access to healthcare for veterans. Clearly VHA is under-funded. Based on VA per capita expenditures for health care in 1996 (the year the system was opened up to all veterans), the need this year would be for \$35.6 billion based on inflation alone (not counting new wars or new programs). Instead the budget was just over \$25 million. CARES is predicated on a peacetime Army. The model is unable to take that into account. The VVA hopes the Commission will look at what the *need* is, not what the *situation* is.

VVA believes that many priority eight veterans either do or should have claims pending. He said prostate cancer is very common for those who served on the ground in Vietnam. VVA estimates that 75 percent or more of those individuals have no clue that their prostate cancer may be related to their service in Vietnam. Consequently, they and their families have no idea that they didn't have to take a financial beating to get it treated. VVA suggests that the Commission ask the VSOs how many claims they have had pending for six months or a year or longer within the VBA. The reason for this is if individuals are in priority eight and they haven't used the system before, they might not be able to use it in the future. VVA is very protective of priority eight (and has taken a lot of flak for it, too). The question will help identify how many veterans are not receiving the medical services they need because their claims are not being processed. Again, CARES begins with what is right now, and VVA doesn't believe that is an adequate reflection of the need.

There has been a debate for many years about whether VA should just serve those who come or should reach out and make sure it reaches those who have been in the military. VVA believes that an outreach component is an essential part of maintaining the trust. The key question is how to do an appropriate needs assessment. VVA knows there are malingers that have demands on the system while people who are more deserving are not calling on it at all. VVA believes VA should take the extra step and reach out to those who are deserving.

Q&A/Discussion

One Commissioner acknowledged that the model is imperfect but said it would fix a lot of problems for a lot of veterans. He asked what VVA's recommendations would be for fixing the remaining blemishes and moving forward.

Mr. Weidman said at first local VVA leaders had wanted to stop CARES altogether because they saw it as the lead in to wholesale elimination of core VA services. VVA accepted the CARES process after hours of discussion with Congressional people, who

made it clear that neither the authorizing nor the appropriations committees would support substantial new improvements without CARES. Now, with the knowledge that the model is data driven, the fear is that the data would inappropriately frame the debate. VVA also was concerned that the formula didn't take into account veterans occupational injuries.

VVA asks the Commission to make sure that the data sets being used are correct and that the formula is changed where needed so that it will lead to good decision making about veterans' future health care . VVA appreciates the Secretary and believes his motivation is right. VVA would also like the Commission to recommend changes in the formulas and data sets for the next round in order to do a needs assessment of the population by cachement area and take steps to begin getting better data.

VVA would also like the Commission to make sure that clinicians are getting information about when and where patients are being served. A Veterans Health Initiative was started in 1999 within VA. There is a web site at www.va.gov/vhi that shows the curriculum that has been prepared on special injuries for veterans. This site is the first time that VHA has ever provided a venue to educate people about the special health care needs of veterans.

Mr. Weidman also recommends adding the patient's military history to his medical record -- when and where served, military occupation, duty station, etc. He cited the shipboard hazard detection program (SHAD) as an example of the kind of duty that ought to be listed. It should be used to help determine what tests the person takes when he comes to VA for care. It would be a step in the right direction.

Asked whether VVA had been briefed on the model used for SCI and special disabilities, he said VVA had been working closely with NCPO and that NCPO had done a great job. He emphasized, however, that special disabilities must be made part of the basic care formula. The veterans' health care system must focus on the medical needs that result from military service.

In answer to a question about improving the data, Mr. Weidman said that it is critical that the Secretary and Deputy Secretary know what's happening with mid-level agency personnel.

A Commissioner said that he was very impressed with the card that Mr. Weidman had distributed and commented that it highlighted the need for medical students to be provided with education, training and information of this type. Mr. Weidman said that work had begun with one special training module. It has been deferred for awhile, but VVA has talked with Dr. Roswell about reinstating the program.

Mr. Weidman agreed to be available for additional consultations with the Commission.

**Presentation By:
Pete Dougherty, Director, VA Homeless Programs**

Mr. Dougherty began by informing the Commission that VA sees about 100,000 homeless veterans every year in the health care system. About 28 percent of these veterans are chronically homeless (i.e. for a year or more or four times or more during the past three years) compared to 10 percent nationally. These veterans are very important to the Department. A significant number -- one-quarter to one-third of the homeless veterans who come to VA -- are eligible for benefits, about half of those for service-connected disabilities. Many have not been successful in obtaining these benefits because of issues stemming from the fact they are homeless.

His office works with outside groups and with other Federal agencies (such as HUD) as an Advisory Committee on Homeless Veterans to provide services to homeless veterans. The Committee has been meeting for about a year. The Committee is concerned that VA's ability to provide long-term health -- funding, services and facilities -- has declined when it should be increased. Domiciliary care is another issue. The Advisory Committee has recommended that VA increase its domiciliary care program, as the VA alternative to community care, to deal with veterans who are homeless. Additionally the Committee has indicated that the homeless program that operates around the country on other-than-VA grounds needs support.

Domiciliary care is important for homeless veterans. At least one domiciliary care facility is needed in every network, but it should be a source of health care, not just somewhere to stay. He recommends that the Commission see if there is a more effective way to deliver domiciliary care to homeless veterans.

The Advisory Committee believes there is a strong need to ensure that homeless veterans benefit from the CARES process; CARES should specifically incorporate the needs of homeless veterans. The Advisory Committee wants to be sure that it has opportunity to participate in the review, specifically to look at mental health. It plans to look at the VISN plans to see what they include related to mental health and the homeless.

Because of its concerns, the Advisory Committee "recommends the CARES Commission reject VISN plans and call for their reconsideration unless at least ten percent of the physical or financial assets achieved in the realignment are considered for use by homeless service providers. All plans approved must demonstrate adequate mental health and substance abuse treatment opportunities with inpatient and outpatient capabilities or the very survival of community based service provider partnerships are at risk."

Q&A/Discussion

One Commissioner commented that the VA approach should involve bringing in homeless veterans, taking care of their health needs and returning them to community life. He said one VA center was planning to move their homeless veterans from a highly urban area to a very rural area, which is not a good idea. Mr. Dougherty commented that 79 percent of homeless people are in urban areas; they generally don't travel around. Those who go somewhere else are usually looking for employment.

In answer to a question about what percentage of veterans are homeless, Mr. Dougherty said that an assessment of 45,000 veterans showed that 28 percent were chronically homeless, which is about three times the national average. Veterans are older and sicker than other homeless people and are resistant to training. Further, their military training equipped them to survive longer. The fact that two to four times the more vets are homeless than their non-veteran counterparts may be caused by factors that draw people to the military in the first place, including substance abuse and mental health issues.

A Commissioner asked about the properties that are run by community agents on VA grounds. Mr. Dougherty said there are 24 on-grounds facilities that range from a floor in a building to a separate building. There are 200 off-grounds facilities. The goal is to double the number of beds in the community over the next few years. He added that women veterans are four times more likely to be homeless than their non-veteran counterpart. Beds are available for women and VA can provide resources to community providers for these women's special needs. Mr. Dougherty said that veterans have to be "clean and sober" to stay in the VA program.

VA is the only Federal agency with real data on homeless programs; they are working with other Federal agencies to improve their data so it will be comparable. Because the VA Homeless Program has been operating for three years, it is more successful in attracting veterans than other programs. The big issue is money; there is no VA policy that encourages directors to fund homeless programs.

Address By:
Honorable Leo S. Mackay, Jr.
Deputy Secretary, Department of Veterans Affairs

Dr. Mackay said the Commission will play a vital role in shaping VA's future. Its role as an independent and objective review body is critical to bringing VA into the twenty-first century. CARES is a critical opportunity for the VA system and for veterans. It is a big undertaking with a lot of interest in the outcome.

Dr. Mackay characterized VA as a victim of its own success. It has made such dramatic improvements in medical care that the demand for services has experienced unprecedented growth. Medical care accounts are stretched to the limit. Medical facilities are at the breaking point. And in some areas of the country, veterans wait months for a routine appointment and even longer to see a doctor. At the same time, VA's infrastructure is obsolete, needs renovation and is located in the wrong places for tomorrow's veteran population.

CARES is designed to realign for achieving positive results: greater access to VA care, enhanced quality of care and a right-sized infrastructure that is efficient and economical. CARES is not about downsizing.

There are many audiences for the results of the CARES program. GAO claims VA is spending \$1 million a day on facilities that don't contribute to the mission. CARES will make better use of that money by reinvesting it to meet significant patient care needs.

VA faces major challenges. One is it must adapt to a shifting health care environment with new technologies and new treatment philosophies. Another is that it must re-tool and operating framework that was designed and built decades ago under a much different concept of medical care. A third is to meet new veteran demands by becoming more accessible.

VA has moved from hospital-centered to patient-centered over the past decade. Consumers are busy and want health care on an outpatient basis. This presents a real challenge to a network that was designed and built for a previous time.

The veteran population is changing. The average age is over 60 and the number of veterans who are over 80 will triple by 2010. This will mean emphasizing geriatric services.

CARES will be a blueprint for addressing these challenges. The questions that should guide the CARES review are:

- Is it good for veterans?
- Does it improve health care delivery?
- Will it have a practical result?
- Does it safeguard the taxpayers' money?

He said if the Commission can answer "yes" to these questions, then VA is serving the veteran as it should and CARES is meeting its goals. CARES is not about bricks and mortar, reductions in service or process for the sake of process. It is about optimizing health care and making sure that veterans get the most accessible, highest quality care VA can provide with the resources available.

The Commission is the steward of the CARES process. Commissioners were chosen for their expertise, experience, wisdom and dedication to veterans. The Commission's job is to deliberate and debate both the information that is the basis for CARES and the decisions that will be reflected in the draft plan that will be submitted to it in June. The Commission's report should assure that CARES data is reasonable and void of any major flaws or oversight. It should address whether the decisions based on that data meet CARES goals. And it should ensure that input from the many stakeholders is heard and considered. The review is not expected to be a rubber stamp

CARES is not a panacea for all issues that face the VA health care system. The Department cannot address all of its problems through CARES.

Dr. Mackay addressed some of the concerns raised by the Commission. Regarding VA's fourth mission -- DoD backup -- Dr. Mackay said he met with DoD yesterday and is engaged in ongoing dialogue. Both he and the Secretary take this mission seriously. A process is now in place for taking on the issues, which will be different from those of the

1991 Gulf War. CARES assumes 85 percent capacity with a built-in surge capacity of 15 percent and VA can contract for more. Facilities that don't contribute to the VA base mission also don't contribute to the "fourth mission." It is more important to focus on the base mission; VA needs 800 more doctors and 2500 more nurses in the next year.

Some aspects of VA health care have been left out of the CARES plan, such as long-term care, domiciliary care and outpatient mental health. The Department is committed to these programs, but the data were determined to need more work before they could be used reliably. The model will be improved and modified and CARES-like aspects will be incorporated into the next strategic plan. But it cannot wait on perfection. Veterans would not be well served by maintaining the status quo.

Q&A/Discussion

A Commissioner noted the Commission's concern with long-term care and the need for a comprehensive system. He asked how the Commission could be sure that these would be incorporated in the next round. He also asked for comment on the Secretary's announcement that DoD would use TriCare, not VA, to back up MTFs for returning casualties from Iraq. Dr. Mackay said the reason for using TriCare backup is that DoD wants to get the casualties back to where they came from. Burns and spinal cord injuries will go to VA. Priority will be given to VAMCs that are within the TriCare network. Regarding long-term care, he acknowledged the existence of contentious issues, including institutional beds for long-term care. Surveys show people would prefer to stay out of the hospital, so there is a real difference of opinion about what the demand will be. There isn't enough demand data for capital planning and good data is needed to convince the cynics. It is not a simple issue. Once better demand data becomes available, the Department will be able to make a policy decision.

Asked about long-term mental health care and outpatient mental health, Dr. Mackay said the Commission can make recommendations to the Secretary, who can take another look before there is a final CARES plan, legislation and appropriations. He acknowledged that categorization presents a tough problem in relation to outpatient mental health and agreed that greater emphasis is needed. He added that soldiers in Iraq are already manifesting stress and will require services.

In response to a comment about stakeholder input, Dr. Mackay said the Department learned from phase I that it is impossible to over-communicate, so phase 2 has been very open. The Department is constructing a capital asset portfolio that includes leases as well as owned facilities. DVA is one of the largest asset holders in the Government. It intends to track and manage that portfolio as if it were an investment portfolio. CARES is a big part of resetting the base and a continuous effort will be made to appropriately manage capitol assets.

