REVIEW PROVISION OF CARE TO IDAHO'S VETERANS

HEARING

BEFORE THE

SUBCOMMITTEE ON HEALTH

OF THE

COMMITTEE ON VETERANS' AFFAIRS

HOUSE OF REPRESENTATIVES

ONE HUNDRED FIFTH CONGRESS

SECOND SESSION

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CONTENTS

OPENING STATEMENTS

	Page
Chairman Stearns	1
Hon. Bob Stump, chairman, Full Committee on Veterans' Affairs	2
Hon. Helen Chenoweth	2
Hon. Mike Crapo, a Representative in Congress from the State of Idaho	4

WITNESSES

Barker, Barry, Regional Office Director	10
Bermeosolo, Gary, Administrator, Idaho Division of Veterans Services	32
Prepared statement of Mr. Bermeosolo	89
Boyle, Arthur, Vice President, Fleet Reserve Association Branch 382	52
Prepared statement of Mr. Boyle	119
Brock, T.C., Senior Vice Commander, Veterans of Foreign Wars	41
Prepared statement of Mr. Brock	108
Galey, William Ted, M.D., Director, Veterans Integrated Service Network 20	11
Prepared statement of Dr. Galey	66
Lance, Alan G., Attorney General, State of Idaho	37
Prepared statement of Mr. Lance	92
Lee, David, M.D., Chief of Staff, VA Medical Center	7
McIntyre, David, President and CEO of Triwest Health Care	18
Prepared statement of Mr. McIntyre	86
Schmidt, Lyza, Wife of General Mark Schmidt	15
Scofield, Shirley, Commander of Disabled American Veterans	39
Prepared statement of Ms. Scofield	98
Smith, Debra, Board of Directors, National Gulf War Resource Center	46
Prepared statement of Mrs. Smith	114
Terriberry, Col. Cynthia, Commander of Regional 366 Medical Group, U.S. Air Force	12
Prepared statement of Colonel Terriberry	79
Tippets, Wayne, Director of VA Medical Center	5
Prepared statement of Mr. Tippets	61
Woodfin, William, Commander, Military Awards of Purple Heart, Department of Idaho	47
Prepared statement of Commander Woodfin	110

MATERIAL SUBMITTED FOR THE RECORD

Letter to Members of the committee from Terrence S. Batliner, DDS, MBA, Director, VA Rocky Mountain Network re VA's enrollment process, June 25, 1998	57

REVIEW PROVISION OF CARE TO IDAHO'S VETERANS

TUESDAY, JUNE 30, 1998

HOUSE OF REPRESENTATIVES,
SUBCOMMITTEE ON HEALTH,
COMMITTEE ON VETERANS' AFFAIRS,
Washington, DC.

The subcommittee met, pursuant to call, at 10:30 a.m., in the Gold Room, State Capitol Building, 8th and Jefferson Streets, Boise, ID, Hon. Cliff Stearns (chairman of the subcommittee) presiding.

Present: Representatives Stump, Stearns, and Chenoweth.

Also Present: Representative Crapo.

OPENING STATEMENT OF CHAIRMAN STEARNS

Mr. STEARNS. Good morning. The Subcommittee on Health and Veterans' Affairs will come to order.

It is a pleasure to be here in the City of Trees as part of our subcommittee's ongoing oversight of care furnished to our Nation's veterans. We are here at the request of Representative Helen Chenoweth, a distinguished member of our subcommittee.

I am particularly pleased that our colleague, Congressman Michael Crapo, is able to join us today. Of course I want to also thank the chairman of the Veterans' Affairs Committee, Bob Stump of Arizona, for his participation too.

In coming to Boise we welcome the opportunity to learn more about the many changes under way in the VA health care system and their local and regional impact. This is a most important hearing, not only because Idaho is an important state, but because it is our first field hearing of the year.

Members of Congress are charged with responsibility for oversight of the VA health care system and need to hear from those who rely on the VA care and from officials with the weighty responsibility of administering and providing that care.

We take our oversight responsibility very seriously; for example, in addition to holding this hearing Chairman Stump and I inspected the Boise VA Medical Center earlier this morning.

Our committee is a strong supporter of the VA health care system and a strong advocate for veterans in Congress. At our committee's initiative Congress has enacted several major laws aimed at improving the VA health care system. This hearing gives us an opportunity to learn how those laws have been implemented and what impact they are having.

Our committee must also look ahead, however, and question whether on the national and local level VA is planning appropriately to meet veterans' future health care needs. We want to gain insight on that question as well.

In that regard, I chaired a hearing earlier this month on the future role of the VA health care system. One of the witnesses at that hearing recommended that Congress should ultimately merge the VA and DOD health care systems into one system under the Department of Defense. I question the soundness of that proposal, but I am interested in understanding its implication both nationally and in an area like Boise where a VA and Air Force hospital are in close proximity to one another.

The merger recommendation raises many questions. But one of the first questions it raises is just how effectively the DOD program is taking care of DOD beneficiaries today.

In that regard, I would like to get some insight today on how effective our efforts to encourage sharing between the VA and DOD health care facilities and DOD contractors have been.

I want to thank the gentlewoman, Helen Chenoweth, for all her help in coordinating and preparing for this hearing, and I want to thank our many witnesses for appearing here today and for their testimony.

We have asked several officials to remain after the hearing to assist in answering questions from members of the audience, and I appreciate their cooperation and assistance. I regret that I will miss some of the question and answer session in order to meet another commitment today, but our staff will remain for the entirety of these proceedings.

Before going any further I would like to invite the chairman of the full committee, Congressman Bob Stump, for his opening comment.

OPENING STATEMENT OF HON. BOB STUMP, CHAIRMAN, FULL COMMITTEE ON VETERANS' AFFAIRS

Mr. STUMP. Thank you, Mr. Chairman. It is a pleasure to be here. As the Chairman said, we are here not only as part of our responsibility of oversight—we oversee a budget of $42 billion—but also to get out and make sure the veterans are getting the services they are entitled to, and that the various VAs are doing what they should do in complying with laws that are passed. We do oversee 173 hospitals in this country and almost 500 outpatient clinics.

I would like to thank Helen for asking us out, and it is a pleasure to be here. And Mr. Chairman, both to you and Helen, for all the work you have done to make this hearing possible. And for all of you that have turned out to witness and to testify before us today. Thank you.

Mr. STEARNS. At this time I would like to ask Mrs. Chenoweth if she has an opening statement.

OPENING STATEMENT OF HON. HELEN CHENOWETH

Mrs. CHENOWETH. Thank you, Mr. Chairman. You know, it is just an awful long way in this big State of Idaho to travel to seek medical care, but it is an even longer way to travel from here to Washington, DC. To be heard with regards to those specific con-

cerns and problems that we face in this very rural state. And like the Chairman said, with the facilities that we have here in Idaho already we need to make sure they are utilized to the maximum capacity, and so because of that I decided to bring the committee to Idaho and it was something that I am thrilled that has materialized. It is indeed my personal privilege to be able to be joined by my colleague, Mike Crapo, and the two chairmen in the veterans' committee, those who have the greatest power in terms of the decisions that need to be made to make sure that our veterans are delivered the health care that have been promised them.

From the time I was a very young girl I was taught to respect our military and respect for the flag and support for our troops at home and abroad was deeply engrained in me as I grew up. And I have seen this nation in her finest hour and I have seen this nation in her most trying times during Vietnam and even times since Vietnam, but my faith in and respect for the men and women in uniform has never waned, not one bit.

Tragically, the promise that we made these men and women has not been kept to the fullest extent of their portion of the bargain. Our commitment as a nation to our veterans is being challenged today as never before. The drastic changes in health care over the past decade have affected delivery of health care for all Americans, our veterans and retirees included. And a variety of complex issues from the aging of our World War II-era soldiers to the wide ranging illnesses arising from the exposure to poisonous substances experienced by our soldiers in the Persian Gulf demonstrates a complexity of the issues that we face today.

Now that is the primary reason why I asked to become a member of the Veterans' Affairs Committee, and I nagged the Chairman until I became a member of that committee and why I fought so hard to get Chairman Stump and Chairman Stearns to join Mr. Crapo and I here in Idaho.

I believe that the battlefield for the brave men and women who serve our country so honorably is no longer one that involves guns and bombs but consists instead of access to medical specialists and quality of care.

The panels assembled today represent a very healthy cross-section of veterans and retirees who deal with the VA and the Department of Defense to receive individual care. I am hopeful that the testimony of these witnesses and the insight of my colleagues and the Chairman, especially, will provide us with some very firm groundwork for solving some of these problems that our veterans and retirees are now facing.

It disturbs me very much to come back home to Idaho and hear our veterans who say they can't get proper treatment at the VA hospital or that they must wait 4 or 5 months to get the necessary orthopedic surgery that they are suffering pain from today.

I am bombarded by complaints from retired military who tell me that under the new Tri-Care system they are no longer allowed access to the military treatment facilities at Mountain Home Air Force Base and that they are unable to find doctors in the private sector who will provide services for them.

Why are retirees unable to find doctors when a network of providers was promised and funded by the Department of Defense, I

ask? And why is the VA unable to provide access to specialists in Boise Valley forcing veterans to fly to Seattle, Spokane, Salt Lake for surgery? Why is this happening? And in a mostly rural state like Idaho where mountain roads and winter weather often make travel impossible why haven't innovative methods of health care including tele-medicine been explored to their fullest capabilities?

It is time to get answers to these questions and this hearing gives Idaho veterans and military retirees the best opportunity that they have had to air their complaints and to demand some answers.

Mr. Chairman, we owe our freedom and our lives to many of those that we will hear from today. Their bravery and patriotism stands as a shining example in a culture where we often mourn the loss of our heroes. And I contend that our men and women in uniform are still the kind of heroes that we want our children to look up to.

The very least that we can do is honor the commitment to provide them with health care that they have counted on since they donned the uniform and risked life and limb to protect us.

Again, I want to say thank you, Mr. Chairman, and say thank you to both chairmen and to my colleague, Mike Crapo, and I look forward to finding answers today to some of these very important questions. Thank you.

Mr. STEARNS. Thank you, Helen. And now it is an honor to ask for an opening statement from my distinguished colleague, Mr. Crapo, who I also serve on the Commerce Committee with.

OPENING STATEMENT OF HON. MIKE CRAPO, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF IDAHO

Mr. CRAPO. Thank you, Mr. Chairman. I appreciate you allowing me to sit with the committee today even though I am not a member of this committee. It is a privilege that I appreciate.

I also appreciate how important it is that the subcommittee, including our full committee chairman, has agreed to hold this hearing in Idaho. I hope those who are here as witnesses or as participants in today's hearing recognize how significant it is that the subcommittee is holding this hearing in Idaho.

There are only a very few, limited opportunities for the committee to travel outside Washington, DC, to hold these investigative and oversight hearings. And for them to choose Idaho as one of the places is a significant honor to Idaho, but also an opportunity for us in Idaho. And I know why it happened, it happened because our good Representative, Helen Chenoweth, who serves on this committee, has been tireless in her efforts to represent and strengthen the interests of our veterans.

Helen and I talk regularly in Washington on veterans' issues and about the importance of making sure that the committee holds its investigative hearings here in Idaho and pays the necessary attention to the veterans' issues. And I knew she would be successful in making sure the committee made Idaho one of the places of focus.

Helen has very well stated the issues that we are here to look at today. I think the only thing that I would add is just a second to everything that she has said. Those who are here in the room today represent very well those across Idaho and across our coun-

try who have put their lives literally on the line for the freedoms that we enjoy in this country. And because of what they have done we have made commitments back to them as a country, and you all know that we are in an era of trying to balance budgets and trying to bring fiscal responsibility to the Federal Government; to downsize the reach of a very large Federal Government that has been consolidating power for years in Washington.

But among the most, I wouldn't even say among the most, I would say the most significant proper function of the Federal Government is our national defense, and its care and its attention to those who participate in our national defense as veterans. And that is why it is so important for us as we work in this process of achieving fiscal responsibility in Washington to make sure the most significant function of our Federal Government to defend our own borders and to care for those who have given of their lives and their time for our national defense, that those commitments are honored. And that is why we are here today.

Again, Mr. Chairman, I thank you for allowing me to sit with the committee this morning.

Mr. STEARNS. Thank you, Mike. Now, I will have our first panel come forward. We have Mr. Wayne Tippets, the director of the Boise VA Medical Center; he is accompanied by Dr. David Lee, the chief of staff; and the Regional Office director, Barry Barker. We also have Dr. William Ted Galey, the VISN 20 director; Colonel Cynthia Terriberry, Commander of the Regional 366 Medical Group at the Mountain Home Air Force Base; Mrs. Lyza Schmidt, wife of General Randall Schmidt; and Mr. David McIntyre, President and CEO of Triwest Health Care.

Gentlemen and ladies, I am just going to ask if you would stand for a second, and we will swear you in for this hearing.

[Witnesses sworn.]

Mr. STEARNS. What I would like to suggest is if all of you will take 5 minutes for your opening statement, perhaps many of you have given us your opening statement, might want to summarize that so that we could proceed because we have quite a number of folks here. And I might start with Mr. Wayne Tippets.

STATEMENT OF WAYNE TIPPETS, DIRECTOR OF VA MEDICAL CENTER

Mr. TIPPETS. Mr. Chairman, members of the subcommittee, Congressman Crapo, it is indeed a privilege to have you in Boise, ID. I would like to start out with a history of the medical center, and then I would like to pass to David Lee, who is going to talk more about the medical programs.

The Veterans Affairs Medical Center is located on the site of an 1863 Army post, which was known as Fort Boise. This was established in July 3, 1963 by Major Lugenbeel, who arrived here via the Columbia River from his command in the Washington-Oregon territory.

He chose this site—he was looking for a site which was on high ground that had a water supply and had sandstone in order to build buildings. We still have three of those original buildings on the hospital grounds. One of those is used for an eye clinic, one is

used for outpatient PTSD, and the other is a guardhouse as you come to the VA grounds.

From 1879 to 1912 the post was known as the Boise barracks. It was largely abandoned except for storage facilities and stables used by Idaho National Guard.

After World War I, veterans with disabilities were cared for by the U.S. Public Health Service under an agreement signed in 1919. The Veterans Bureau, which was created in 1921, took over the facility then designated as Veterans Bureau Hospital 52. The Veterans Administration formed in 1930 has operated the hospital ever since.

The Boise VA Medical Center, affiliated with the University of Washington is a modern facility offering primary and some secondary care to some 70,000 veterans who reside in 23 southwestern Idaho counties and four counties in southeastern Oregon.

Our primary service area, which has a radius of 160 miles, extends east to the Twin Falls area, west into eastern Oregon, south to the Nevada border, and north to the Lewiston area.

Eastern Idaho is served by Salt Lake while northern Idaho is served by the Walla Walla and Spokane Medical Center. Approximately 70 percent of our veterans come from Ada and Canyon County where we have a market penetration rate of almost 20 percent.

I would like to discuss efforts which we have made to increase access to veterans living in Idaho. During the previous 3 years we have provided care for 11,000 individual veterans with 99,000 outpatient visits.

In 1997 we obtained the names of veterans, with service-connected disabilities rated at 10 percent or higher who were not using the VA facility. We established health screening clinics on Saturday at the Boise VA and in Twin Falls and Ontario.

As a result of these efforts our workload has increased 11 percent this year in outpatient visits and we are projecting 110,000 outpatient visits.

I would also like to compliment the DAV, which helps us run a transportation support system for veterans from rural areas to the VA Medical Center. We are running four or five vans in cooperation with the DAV; putting 200,000 miles a year on those vans transporting 3,300 veterans to the hospital for medical care.

In the past 3 years we have added a number of programs which have increased care to veterans at our hospital. We have increased ophthalmology; if you look back 3 years ago, we had a half-time ophthalmologist which now has been increased to a full-time ophthalmologist, a full-time optometrist, nurse, and an ophthalmology tech.

We have increased our dermatology clinics from one clinic a month to three clinics a month; we have increased podiatry from one clinic a month to three clinics; we have increased gastroentrology from the use of a consultant in the community to a full-time gastroentrologist on our staff; we have increased oncology from half-time physician coverage to three-quarter coverage plus an additional nurse.

We have initiated a hospital-based primary care program (HBPC) in the community; we now have 100 vets getting care in

their homes. We have initiated a hospice program; we have initiated an outpatient mental health program in an effort to keep individuals out of the hospital.

We have started an inpatient PTSD program at the medical center, we have implemented a Gulf War veterans' program, we have started a halfway house for mental health substance abuse patients, and we have increased our ENT from the use of a consultant in the community to a half-time ENT physician.

We have also been approved for a community-based outpatient clinic, which we hope to get started on October 1 of this year in the Twin Falls area.

I am extremely proud of the quality of health care provided at the medical center as well as the quality of the employees who provide this care. And I would like to end my testimony by saying, outside of the medical center there is a sign which says, "The price of freedom is visible here." It is an old sign, I have no idea how long it has been there, 20 or 30 years, but it is certainly true, and I hope this country never forgets that we need to provide adequate health care to those veterans who have served this country and are the reason we are all living in freedom today. Thank you very much.

[The prepared statement of Wayne Tippets appears on p. 61.]

Mr. STEARNS. Thank you, Mr. Tippets. Dr. Lee.

STATEMENT OF DAVID LEE, M.D., CHIEF OF STAFF, VA MEDICAL CENTER

Dr. LEE. Mr. Chairman, Congressman, friends, I too am very honored that you have chosen to come to Idaho to see the operations of our health care system here.

Our medical center's mission is stated as to care, heal, teach, and discover. The discover part refers to the discovery of new knowledge, which of course, relates to the medical research programs which we also have.

If I were to summarize some of the characteristics of this particular VA, I think I would say that we have emphasized a considerable amount of innovation. That innovation is always in the interest of patient-centered care and quality services. In some ways I think I would also like to characterize us as an overachieving mighty mouse. Chairman Stump mentioned that there are roughly 173 medical centers at the present time. I think our rank in the budget of those medical centers is somewhere around 154, so we are, in budgetary terms, one of the smaller VA centers, and yet we have striven to use the resources that are available to us to provide as much care as we possibly can.

I would like to highlight a few things about the type of medical care which we deliver and begin with primary care. This dates back in some ways to our 1977 affiliation with the University of Washington in Seattle. While that affiliation is important I don't want to overemphasize it; it is a means to some of the quality patient care that we deliver, but it was the start of primary care because the affiliation began as a primary care residency.

Now, in 1998 primary care is very fashionable and most health care systems want to use that as a foundation. But in 1977 that was quite apart from the norm and it was something very distinc-

tive. Even then, however, we realized that that was a critical need for a rural state like the State of Idaho and it was going to be terribly important to have primary care providers available to the population.

As a result we crafted a system where the residents spent their first and third years in Seattle doing tertiary care, but their second year was entirely spent here. Future physicians get the real flavor for what it is like to practice primary care in a smaller community. And sometimes when something is not unknown it becomes a very viable career choice.

Through the years the university has expanded in rural areas and now seeks additional training care sites with graduates of the program who have gone into primary care in rural Idaho so that again new generations will see rural primary care as a very viable future career choice.

To this point in time some 170 physicians in Idaho have received at least part of their training at our site; 90 percent of those are in primary care, many of them are in rural sites. In a given year we will have 22 residents, some 256 residents total have gone through our program, 35 to 45 medical students, (394 of those in total have spent some time in our program), and physician assistants. And the University of Washington in recognition, in part, of their partnership with us, is ranked by U.S. News and World Report as the number 1 primary care training medical school throughout the United States, and is also in the top 10 in terms of research. And that is an unusual pairing, that a medical school is seeing excellence in both of those fields.

The primary care model has been tremendously important to us because beginning in 1977 we recognized that for a patient to have a physician they would see practically every time they went to the medical center was terribly important. It is important to the patients, it is important to the physicians, and I contend that it is one of the most important things in delivering high quality care. Every time I see a patient I don't have to reacquaint myself with their entire past history. I already have an acquaintance with that. And as a result I am going to miss far fewer medical problems.

We expanded on that continuity at the physician level by being one of the pioneers in establishing primary care teams so that not only the physicians but also the nurses and the clerks who dealt with the patients on a regular basis would be familiar with the patients and there would be continuity of care. To that we added a telephone triage program where again the patients have the opportunity to call into nurses by now familiar with them and with their issues. The efficiency and effectiveness of having that continuity has been indispensable.

The final innovation in primary care has recently been added, and we have nursing case managers who take some of the more difficult cases or the more complex cases and manage them very specifically providing additional channels of communication in health care expertise for both the patients and their families. That too has been a very successful innovation.

Beyond our medical school affiliation with the University of Washington, we also have provided health care provider training

for the Boise State School of Nursing, the School of Social Work, and the Idaho State Pharmacy School, among others.

I am tremendously proud of the quality of staff that we have. Many of my staff have been presidents of state, national and even international, community health and scientific organizations. And one of the things which gives me the most pride is that in a patient satisfaction survey done nationally by the Department of Veterans Affairs, we were scored as a site of excellence in all six categories of their range. Very few other facilities achieve that kind of distinction. And nothing pleases us more than the fact that we are pleasing our patients in the services that we deliver.

I also mentioned research. That, of course, is a part of the VA budget. We have $1.6 million in health care research which took place at our facility. The discoveries there benefit, of course, not only veterans but also the entire Nation.

In mental health, Mr. Tippets has already mentioned the intensive psychiatric community care program. That too has been a wonderful innovation, which has kept very complex mental health patients in the community and not institutionalized.

In substance abuse we crafted a continuum of care where we have residential programs in a community house enabling the people with substance histories and problems to get back into the community and effective life.

And then we have the extended PTSD program, which is a referral program serving many states, and patients with specific problems related to post-traumatic stress disorder can have a consultative long-term state to deal with those very complicated issues.

In surgery, we offer high quality general surgery. We are pioneers in the valley in laparoscopic surgery and ambulatory surgery. To this point in time we are one of the highest ambulatory surgery providers. Some 70 percent of our surgery is done on an ambulatory basis. And for a mighty mouse we offer a considerable amount of specialty surgery as well.

Vascular surgery, Mr. Tippets has mentioned the enhancements of ear, nose, and throat surgery, ophthalmology, urology, and even some thoracic surgery. Orthopedics is legitimately a problem. I think part of that is a contextual problem where the prevailing community salary rates are roughly four times the average VA salary. So despite the fact that we have had ongoing recruitment efforts we have not been successful. I will come back to that, though, because we do get some wonderful support in that regard.

In nursing we have had a couple of other prominent innovations; one is that we changed our wards from being based on the discipline of the physician who is caring for the patient to centering around more of what the nurses, who are actually on the care units, needed to have in terms of intensity of staffing. That has been very effective, and I have already mentioned the nursing case managers and the outpatient primary care area.

Another feature of this comparatively small VA that I think is important is that we get tremendous cooperation from the community. The health care community in Boise is superlative. It has often been ranked in national rankings as part of what makes Boise a very attractive place to live.

Many of these community providers give us fairly freely of their own time for either nothing or for a minimal remuneration, often taking times away from their own very busy practices. They do that for many reasons; some do it because they enjoy the teaching and the affiliation with the academic programs, others do it out of very sincere gratitude to veterans and what they sacrificed for us all, many of them are veterans themselves.

Presently we have 84 currently active community consultants. And one of those is an orthopedist who is under considerable pressure from his own partners to come back to their practice because they are very, very busy. Yet he continues to provide us services because of expressed, very deep gratitude for what veterans sacrificed during the wartime periods.

Sharing is another important aspect, and I suspect we will talk a great deal more about it. We are very active partners and have really taken the initiative in dialoguing regularly the two regional medical centers in town: St. Luke's and Saint Alphonsus hospitals. Mountain Home Air Force Base are partners, with the Department of Veterans Benefits, and the state as well as, of course, in the larger integrated service network which Dr. Galey represents. And we are now rapidly exploring the telemedicine that Congresswoman Chenoweth mentioned as a way of dealing with some of the challenges of our dispersed rural population and providing health care to it.

The growth has been significant. We created a very beautiful new primary care building, and as a result we have exceeded almost the capacity of that building already by adding roughly 1,100 new unique veterans through the programs and the outreach that Mr. Tippets mentioned. We have the foresight that we are using some of the back——

Mr. STEARNS. Dr. Lee, can I just have you summarize your——

Dr. LEE. Yes. Back fill sites and the old hospital for additional primary care capacity. I will be happy to quit there.

Mr. STEARNS. By unanimous consent, the main portion of it can be part of the record if you wish to put anything that you haven't provided. Mr. Barker.

STATEMENT OF BARRY BARKER, REGIONAL OFFICE DIRECTOR

Mr. BARKER. Mr. Chairman, members of the committee, I want to thank you for the invitation this morning. I don't really have an opening statement. While this subcommittee deals primarily with health care, as you know, I deal with the benefits side, so I am here primarily to answer questions that may come up on benefits.

I would like to mention one thing; we are the smallest regional office, strictly regional office, in the country still representing 112,000 veterans. Our biggest challenge right now is processing claims timely. We have recently hired three people, which doesn't sound like a big deal to most people but three people is 10 percent of the staff I presently have processing claims so it is a very big deal for us. And as we get them trained we think we can do a much better job in timely processing of claims. Again, I thank you and I am here for questions on the benefit side.

Mr. STEARNS. Thank you. Dr. Galey.

STATEMENT OF WILLIAM TED GALEY, M.D., DIRECTOR, VETERANS INTEGRATED SERVICE NETWORK 20

Dr. GALEY. Mr. Chairman and members of the subcommittee, if you are visiting the northwest network for the first time, welcome; if you are fortunate enough to live here, welcome home.

I would like to begin today by describing the unique features of the veterans integrated service network 20, which is also known as VISN 20. The northwest network covers the states of Alaska, Oregon, Washington, and most of the State of Idaho; it is six medical centers, one independent domiciliary, one independent outpatient clinic serve approximately 115,000 unique veterans or about 10 percent of the 1.1 million veterans within our geographic area of responsibility in fiscal year 1997.

Included within these facilities are seven nursing home care units, three homeless domiciliaries, 15 readjustment counseling centers, six currently approved, two currently proposed and 14 planned community-based outpatient clinics will significantly improve access to northwest veterans and increase the unique patients served between now and 2002.

The northwest network has an operating budget of $672 million and employs 7,300 people. The network has a research budget of approximately $24 million and ranks fourth among all the networks in overall research funding.

In support of our educational mission the network facilities have a total of 292 affiliation agreements with both regional and national academic institutions. The network covers approximately 788,500 square miles, 72 percent of which is the State of Alaska. Most facilities are 150 to 500 miles apart while Anchorage, on the other hand, is 2,500 land miles and 1,500 air miles from the nearest VA facility. The geographic spread, mountainous terrain, and hazardous winter weather conditions offer special challenges for the network in developing and integrated services delivery system.

Well, what is an integrated health services delivery system? Dr. Steven Shortell (phonetic), one of the leading experts on U.S. Health care systems, defines it as a network of organizations that provide or arranges to provide a coordinated continuum of services to a defined population.

Furthermore, the network is also willing to be held clinically and fiscally accountable for the outcomes and health status of the veteran population served.

In pursuit of this model of health services delivery we are rapidly moving away from a hospital-based system to one based on primary care, the continuity of care, collaboration, and connectivity throughout the system. We are reorienting our resources to fund information management and communications infrastructure to assist in the smooth flow of veterans and their patient care information through the system.

We are increasing access to core surgical and medical specialty services by investing in VA providers and staff, or as another option, we may purchase services where it is more economically feasible and legal to do so.

We are further increasing access by opening a planned total of 22 community-based outpatient clinics in the northwest by 2002 and by developing telemedicine capacity to remote areas.

We strive to be an accountable health care system using data, information, and objective measurement of performance and change to continually identify opportunities to improve with sound management, attention to best practices, and applying primary care and VA care principles of wellness, disease prevention, and care management of disease.

VISN 20 has the human and financial resources to continually improve the access to and the quality of health services for veterans now and in the foreseeable future. Thank you for the opportunity to address you today.

[The prepared statement of William Ted Galey appears on p. 66.]

Mr. STEARNS. Thank you, Doctor. Colonel Terriberry.

STATEMENT OF COL. CYNTHIA TERRIBERRY, COMMANDER OF REGIONAL 366 MEDICAL GROUP, U.S. AIR FORCE

Colonel TERRIBERRY. Distinguished members of the subcommittee, I want to thank you for this opportunity to meet with you and discuss sharing between the 366 medical group—the missions of the military health system and the Veterans Health Administration are similar. We serve those who serve or have served in the armed forces; consequently, the 366 medical group and the Boise VA medical center see each other as partners in a long-term relationship to provide care to loyal Americans and their families who have been called to serve our Nation, not simply as another entity in the health care marketplace.

Our two organizations have had a close working relationship since the early 1980s from Public Law 97–174, which first encouraged DOD and VA sharing. Our missions are also different. We have an extremely large commitment to combat readiness in our current unit, the 366 wing at Mountain Home. We also serve a much younger population. These differences temper the sharing that we can do.

At Mountain Home Air Force Base we operate a small Joint Commission accredited community hospital with approximately 400 military, civilian, and contract personnel. Our major services are primary care, emergency services, surgery, OB and gynecology, mental health, aerospace medicine, internal medicine, pediatrics, preventive medicine, and dental services.

We operate just two inpatient nursing units; a multi-service unit and an obstetrical unit for a total of ten authorized beds. Last year we had an average daily patient load of seven and delivered 330 babies. We performed almost 1,800 surgical procedures on either an inpatient basis or in our ambulatory procedure unit. We have 12 primary care providers, eight specialists and eight dentists who provide our care. Last year we had over 88,000 outpatient visits. As you can see, we have a small staff with large responsibilities.

To best guide the use of our shrinking medical resources Air Force-wide, the Air Force Surgeon General has established what we call the "strategic pillars." We use these pillars to guide our daily efforts and our future planning. Picture a parthenon with four pillars and a capstone. The pillars are labeled: Readiness, Tricare, Rightsizing, and Building Healthy Communities. The capstone is labeled Customer Satisfaction.

The readiness pillar is job one at the 366th medical group. We require 100 percent of our military personnel to meet stringent requirements to mobilize on a moment's notice. Over half are committed to specific jobs under various contingency plans. Over one-third have deployed for at least 45 days in the last year alone.

In support of the second pillar we have implemented Tricare in April of 1997. Tricare, as you know, offers three benefit options to active duty families and to retired families who are not Medicare eligible. We manage this benefit through our contracted partner, Triwest.

Our customers' number one complaint with Tricare is that Title 10 strips them of Tricare eligibility at age 65 when they become Medicare eligible. At Mountain Home this effectively eliminates them from military health care because our system is filled with Prime enrollees. Currently, military personnel are the only federal employees who lose their employer-provided health plan at age 65. These loyal Americans were promised health care for life as compensation for their dedicated service to our Nation. As Congresswoman Chenoweth has already noted, this promise has been broken, and they know it. The solution is to provide them a benefit.

Operationally, our number one problem is our contracted partner, Triwest, has not been able to develop an adequate civilian provider network for us. There is simply more demand for medical services in Idaho than there are providers. This is compounded by the fact that the contractor is limited to bargaining for services to the CHAMPUS maximum allowable cost or the "CMAC" rate. These rates are comparable to Medicare. Large commercial insurance carriers in Idaho pay billed charges. In essence, the Tricare program assumes that there is a competitive market; in Idaho there simply isn't. The solution is to market-base the CMAC rates and to incentivize competition in the market.

The third pillar is rightsizing. The military drawdown and advances in medical technology have driven a reduction in the Air Force medical services. In 1989 we had over 125 facilities worldwide. Today we have less than 85. Between now and the year 2003, we will further reduce our personnel another 17.9 percent. Many hospitals will become outpatient clinics. We do not anticipate any reduction in the 366th medical group. Our challenge, therefore, is to produce or arrange for services in the most effective and efficient manner. Toward this end, we have begun planning for a women's health center and a community counseling center. We have also been designated as a DOD Beta test site for a version of the clinical integrated workstation which will automate the providers' desktop and patient handling process and provide more time for the provider to take care of their patients.

The Surgeon General's final pillar is building healthy communities. We offer a vast array of preventive medicine services such as public health functions traditionally done by county public health departments; bioenvironmental engineering; family advocacy; and a state-of-the-art health and wellness center. We are currently preparing a community health needs assessment so we can target our efforts to increase the health status of our customers.

The capstone of the pillars is customer satisfaction. We have a long tradition of pleasing our customers, and we have a comprehen-

sive approach to systematically manage how we treat our customers that we call "positive service." It has been so successful that the Air Force medical service designated us as one of five customer service model sites.

As part of this program we have our patients literally grade us on a customer report card. They rate our services A, B, C, D, or F. Using a traditional 4 point grading scale, I am happy to report last quarter we had a 3.7 grade point average. On DOD surveys, our customers consistently rate us better than the civilian HMO customers rate their HMOs.

Hopefully this gives you an idea of who we are and the challenges we face. It is important to understand this to have the overall picture when considering our opportunities for VA sharing.

We have a long, successful history of sharing with the Boise VA dating back to the early 1980s. Over the years we have purchased nuclear medicine, radiology special procedures and routine X-rays, outpatient specialty consultations, inpatient psychiatric care, and a limited amount of other inpatient services from the VA. We have sold physical therapy and GYN services to them.

Today the VA is a Tricare network provider for us. They provide some mental health and medical/surgical capability. Last year 4 percent of our total customers who were referred to other facilities for care were seen at the VA. We paid the VA $92,000 for these services. There are several factors that keep us from using more VA services. One, the VA operates in the same market we do and, therefore, has many of the same shortages of sources of care that we have. Another is demographic. Our population is significantly younger than the VA's. Our median age of the active duty force is 28, and we have many women and children customers. Consequently, we seek other sources of care.

Regardless of these differences I do see some opportunities for increased sharing. We could use part-time providers in ENT and gastroenterology. If the VA had capacity, we could use it, but here again, those specialties are scarce in the local market. If the VA had primary care managers with capacity to take new patients, we could enroll Tricare prime patients who live in Boise to them. And once we complete our community needs assessment we will share it with the VA.

This may point to opportunities to pool the demand of certain services that we could jointly develop. We may also be able to offer some limited services to female veterans once our women's health center concept is fully developed.

And lastly, there may be some potential to sell the lifestyle changing services of our health and wellness center to the VA.

Thank you for giving me the opportunity to meet with the subcommittee, and hopefully I have been able to give you an appreciation for our mission, resources, and the direction that we are taking related to the VA sharing. Thank you.

[The prepared statement of Colonel Cynthia Terriberry appears on p. 79.]

Mr. STEARNS. Thank you. Mrs. Schmidt.

STATEMENT OF LYZA SCHMIDT, WIFE OF GENERAL MARK SCHMIDT

Mrs. SCHMIDT. First of all, I would like to thank you for allowing me the privilege to be here today. I sit in a unique position, and I hope I do justice to the people who use the present health care system for military families and retirees.

In that unique position I must clarify my position on this panel today. I am the spouse of an active duty Air Force member. As such I have used the Tricare contractor, Triwest, and the military treatment facility, MTF, for my own health care as well as the health care of my three sons.

My comments today reflect my own personal observations and opinions. They in no way represent the United States Air Force, the Department of Defense, or any member of the United States Air Force. Also, another disclaimer here, I am not here to represent the views or opinions of my husband, General Mark Schmidt; however, I am very active in the military community; I participate in many activities and many private organizations and am privy to hundreds of spouses' and family members' views on this medical system and how it works. While I have no authority to officially represent them I feel it necessary to relate their views and opinions on this matter.

First, I must concede that Tricare is a given, it is not an option. It is our health care system and we must all push to make it work; we have no other alternative. Today, as in every day, my goal is to help it along, help it become everything we need it to be. I would like to address numerous areas in which I believe our health care system is failing to meet satisfaction standards that military families expect and deserve.

I have four points that I would like to make in case I get cut off. First is, Idaho is medically underserved, Tricare insurance is not user friendly, Tricare through Triwest seems to be an indirect and disjointed system, and finally, supplemental policies are not feasible or affordable.

First, under the Idaho is medically underserved, doctors who have signed up to accept Tricare are mostly already close to capacity for patients, so they don't have many slots for new patients. Doctors aren't willing to sign up because they do have plenty of regular paying clients, and they like being fee-for-service physicians. Due to the fact that very, very few doctors are signing up beneficiaries have extremely limited options and in some cases no other option than standard CHAMPUS, which can be quite costly. Generally it entails an 80/20 split of cost, plus a large deductible and that deductible has grown greater now that we have Tricare.

Some Idaho doctors have had bad experiences with CHAMPUS, which has been a factor in bringing them in on the Tricare bandwagon and getting them to accept CHAMPUS now. Unpopular options have begun creeping into our health care system due to the fact that so few doctors are in our network; maybe, too, the cost-cutting efforts.

Triwest has begun referring patients within the MTF, or medical treatment facility, to doctors who are not specialists, but have some training in a specialty area. This is unfair to the patient, the doctor seeing the referral patient, and the referring physician. If a patient

is deemed to require the care of a specialist he or she needs to see a specialist not a middleman that hopefully has enough training for that specific case. In many instances this practice delays proper treatment, undermines confidence in the Tricare programs, and causes much frustration. And since I wrote this testimony I found out that this is a common practice in HMOs.

As a result of the lack of options some patients feel cornered to use a doctor that they would rather not see, i.e., a patient has asked around and doesn't like what they have heard about treatment given by that physician by someone else. Frequently, the only physician available in the specialty is in a location that is very inconvenient or has so few openings available that timeliness of treatment is inconvenient for the patient.

Remember, all military families live on a fixed income. Many families feel cornered to just accept any care they can get because they can't afford any other option. Many stories of military family patients being treated as though they were welfare cases by referred physicians have surfaced, causing embarrassment and anger. Most cases are of patients made to wait longer than regular, real paying clients.

Secondly, Tricare insurance is not user friendly. I am sure this isn't the first time you have heard that either. This insurance system is very difficult to understand and use, it incorporates lots of intricate instructions and ambiguous rules that every beneficiary must know in order to make this system work for his or her family. Affordability is supposed be a benefit; however, out-of-service-area claims cause anxiety because even if a beneficiary calls to get access to care he or she can be denied access to care, or given access to care then told to wait for reimbursement, which in the end never comes.

Most feel that the ability to care for your family in an out-of-the-service area is a hassle or a fight that you must face should the need arise. The problems of balanced billing, untimely minimal reimbursement, and refusal to pay claims have become a major factor to those families who must leave the military treatment facility to seek medical care.

Many beneficiaries who require care may chose no care than to wrestle a system they don't understand and seems hostile. Many who do seek care then experience the hassle to recoup moneys deserved, give up and pay more than they should just to avoid the pain, frustration, lost job time, and possible smudge on his or her military record.

Families of more junior ranking members face the uncertainty of being able to pay a large bill, intimidation of using this system, and damage to their credit rating. Most of the time these junior members must use a first sergeant to help negotiate the system.

Thirdly, Tricare, through Triwest, seems to be an indirect and disjointed system. Physician referrals have no response correspondence back to the primary care managers. Once a patient leaves the military treatment facility to be seen there is no process in place to get that primary care manager, the status of care, diagnosis, or follow-up treatment that has been provided. However, the primary care manager is supposed to be the primary physician in that person's life.

Many people providing care within the MTF do not understand the rules of engagement used to make Tricare work for the patient. The contract under which Triwest is administered is often viewed as a limiting factor, not an empowering one; therefore, care is sometimes denied or postponed because the caregiver is unsure if the contract prohibits him or her at that point in time.

Beneficiaries feel very uncomfortable dealing with the impersonal Triwest office. No privacy, walk in, sign in, wait to spill your guts about your bill or to complain about a process you cannot change. I have heard many complaints about customer service within this system.

The appointment process has also been a source for disillusionment. You are sick, you call in, and someone on the other end tells you—decides how sick you are and when you will get seen. And even though everyone knows that our particular Tricare network doesn't work the way it was designed, i.e., lots of options to receive care, our military treatment facility is now going to be funded on a capitation schedule, so that the MTF will only now receive funding for those individuals who have enrolled in Tricare prime. So any family that has opted to try other means for medical care will be put on a space-available mode to be seen at the MTF. That includes retirees and active duty families. Patients feel locked into a bad thing that even the chain of command cannot help them with since the contract prohibits the MTF personnel from going to the top for solutions. From what I understand the commanders in the MTF must follow a contractual protocol dealing with the Triwest hierarchy. There is no provision to go to the top when something needs to be raised to that level.

Lastly, supplemental policies are not feasible or affordable. People who hear these recommendations often suggest that military families sign up for supplements to Tricare as a solution. I suggest that in many cases this is either unfeasible or unaffordable, but in all cases should be unnecessary. The supplements that are on the market and available to the military family generally have a time period before they become effective; most, 6 months to 1 year. Some even restrict access to prediagnosed illnesses; therefore, those who are the sickest and possibly in more need could be denied.

Again, the military family is on a fixed income. Medical care is something that has always been provided as a benefit. As such, a military family generally does not have the extra disposable income, $300 to $500 per person, per year for a policy supplement. What person in this country who has a comprehensive commercial policy like Blue Cross and Blue Shield feels the need to purchase extra insurance?

In closing, it is my hope that with all the information presented here today our health care system, Tricare, can evolve into a better system to provide the military family with the quality care that they have enjoyed with the military system. I also hope that as it evolves Triwest and Tricare will also enjoy the heightened confidence level that goes along with high competence and compassion.

In the end, I know that this new system is centered around a business, and a business by definition should make money. Just please realize it is a huge change for the entire populace for which care is provided. As we speak your Tri-West position with these

beneficiaries is one of adversary. Few like what they have been dealt and will continue to fight until they get what they want and deserve.

Thank you for your time and consideration on behalf of my family and all those military families who also serve their country in one form or another.

Mr. STEARNS. Thank you, Mrs. Schmidt. Mr. McIntyre.

STATEMENT OF DAVID MCINTYRE, PRESIDENT AND CEO OF TRIWEST HEALTH CARE

Mr. MCINTYRE. Chairman Stump, Chairman Stearns, Congresswoman Chenoweth and Congressman Crapo, I would like to commend you for holding the hearing today to review the provisions of care to Idaho's veterans.

In my view there is a no more deserving population than those who have stood in harm's way in defense of our country in its times of need. Given the compelling testimony that we have just heard I am somewhat at a loss as to whether I ought to respond extemporaneously or whether I ought to give my prepared remarks. I am going to follow closely my prepared remarks, but I will be available for any questions or comments that you would like in response to the compelling testimony that we have just heard.

This system represents a fairly dramatic change from what was in place historically. It is complicated. By its very nature, insurance is complicated. And when you go through the kind of process that we have gone through over the last year, bringing up such a massive new program, it takes a while to stabilize things.

Since April 1997 we at Triwest, including our Idaho-based owner, Regence Blue Shield of Idaho, have been honored to have the opportunity to serve the Department of Defense as it seeks to meet the changing health care needs of the more than 700,000 Tricare beneficiaries that reside in the 16-state Central Region that we serve, including 24,000 of which reside in the rural State of Idaho.

As the contractor we are responsible for, among other things, assisting in the marketing of Tricare, enrolling into the HMO-like option of Tricare, and building and maintaining a network of hospitals and providers to deliver those services that can't be delivered within the MTF environment.

We operate within a set of rules that are prescribed both by the government as well as the ones that Congress had had involvement with in setting up this program.

One of the military treatment facilities in our region, in fact the one nearest where we are meeting today, obviously, is located at Mountain Home Air Force Base.

We have subcontracted our network development responsibility to the Blue Shield plan in this area, believing that the best and most successful way to build a network in a rural state like this was to look to the major insurance company. One of the things, however, that has impaired our progress has been addressed even this morning before I testified. And that is the fact that the reimbursement rates for both Medicare and in turn Tricare are significantly different in Idaho than commercial marketplace reimbursement for the same services.

Congresswoman Chenoweth has been working on this issue for some time and; I think her leadership ought to be applauded. The fact of the matter is, however there remains a significant disparity. So when you go to a provider who already has a full patient load, and then you say under this program we are going to provide you with 50 percent of what you might have otherwise received for those same services had you delivered them to the beneficiary of a commercial insurance company in this market, they say, sorry, I can't do it. And that is a very real challenge. We have been working with the Department of Defense on that very issue.

We and our shareholders have contacted numerous VA facilities in our region, and are working at building what we hope will be a good relationship with the Boise VA. In fact, we have as many as 30 VA facilities in our network across the 16 state area. I believe that the partnership that has existed between the Department of Defense and Veterans Affairs for years now, and that now involves companies like Triwest, is critical for several reasons. One is it maximizes access to health care for beneficiaries of these programs, particularly in rural and medically underserved areas like Idaho.

Second, there is a good amount of sharing going on in our region between the DOD, VA and ourselves. In several communities throughout our region, the VA facility and the MTF are located fairly close to one another. In several communities in our region, the VA facility and the MTF, are actually one facility. This sharing ought to be applauded.

Third, sharing maximizes the investment that the taxpayers have made in these two systems and that is a good thing at the end of the day, at least from my perspective. As I said, we are pleased with the relationship, and we think that it is growing. Should the two systems ever be merged? I don't know the answer to that question. The missions are slightly different, the system's goals are slightly different, but the fact of the matter is that there has to be—continue to be a very serious and close working relationship.

One issue that I would like to address very briefly, and quite frankly, I think you all could act on, is an issue that would help resolve some of the shortage problems in medically underserved areas. We have talked about the issue of resource sharing today where you allow VA providers to come and provide services within the military treatment facilities. There is another provision under the law that actually allows you to bring providers outside of the State of Idaho into Idaho to deliver services, under what is called Resource Sharing. There is a glitch in federal law, however, that does not allow you to bring a provider into a state unless they have a license to practice medicine in that state. This applies to contractor supplied providers, and Resource Sharing is a contractor responsibility. Historically, however, a provider may be brought into a VA facility or into a military treatment facility by the facility, even if they did not have a local state license in that state. The glitch in the law ought to be changed. This will make Resource Sharing a more helpful tool to help address the access problem in this area for these beneficiaries.

I would last like to say, Mr. Chairman, that I would be remiss if I didn't express our corporation's support for all of the work that is going on on the Medicare side, both with regard to the Department of Defense programs as well as the VA. Thank you for your leadership in that area. That has been long in coming, and my hope is that we soon see demonstrations both for the VA and DOD.

In closing, I would like to say that while we have some challenges and we continue to work some of those through, that Triwest and our Idaho-based owner, Regence BlueShield of Idaho, we consider it a privilege to assist the Department of Defense, and more specifically, the military treatment facility at Mountain Home Air Force Base in meeting the health care needs of the Tricare beneficiaries in this region. I look forward to addressing any questions or comments or responding to the very compelling testimony given prior to mine. Thank you.

[The prepared statement of David McIntyre appears on p. 86.]

Mr. STEARNS. Thank you, Mr. McIntyre. Again, I can see why Mrs. Chenoweth wanted to have the hearing here after listening to the testimony this morning. And of course, some of the areas do not necessarily fall into our committee, but we are fortunate with Chairman Stump, he is also the vice chairman of the National Security Committee. So it is probably appropriate to have Mr. Stump here to understand and take back some of these views that are dealing with the Air Force base that the Colonel mentioned and also the whole general issue dealing with the problem of the veterans, retired military people and active military people and their dependents.

We had the opportunity yesterday, last night, to talk to almost 200 veterans who voiced a lot of the problems that Mrs. Schmidt has talked about. And I would like to start off my line of questioning. I will take my first 5 minutes, and then we will continue with the other members here, if I might.

To you, Mr. Tippets, perhaps maybe a yes or no on this question. Would you agree that the length of time veterans must wait for a specialty appointment at the facility is a problem? Just yes or no.

Mr. TIPPETS. Yes.

Mr. STEARNS. And is waiting time a priority for the facility? I mean, is that a high priority? Because what we heard a little bit about is that waiting time is a bit of a problem. Is it a priority, and if so, you might want to tell us what you are trying to do to perhaps recruit specialists or to provide more research or just what extraordinary measures you may be taking.

Mr. TIPPETS. It is obviously a high priority with us. The long waiting times are mostly in specialties that we discussed earlier. I am sure we have several months' waiting time for orthopedic surgery, we have a waiting time for the eye clinic. These are areas where we are forced to transfer patients to other medical centers for care if we can't do it locally. We are continually trying to recruit an orthopedic surgeon. As Dr. Lee said, we haven't found one yet; we are continually expanding our eye clinic as we are able to, but there is an unmet demand for those areas.

Mr. STEARNS. So what specialty areas do you feel that you have a problem with length of time?

Mr. TIPPETS. I would say orthopedics. And I would ask Dr. Lee maybe to respond to that, if he would.

Dr. LEE. It is a very high priority with us and we, quite frankly, monitor it on an ongoing basis. In some subspecialties we do fairly well, in others, as soon as we increase capacity that capacity is met and then exceeded.

We have mentioned the increase in ear, nose, and throat and yet even at that I think we are now up to a 6-week waiting time; we prefer to keep that under a month. In neurology, for quite some time, we were able to keep that within reasonable bounds and recently that, too, has increased to approximately 2 months.

Ophthalmology remains a major challenge despite the fact we have more ophthalmology support than many other VA medical centers our own size. And then the greatest of them all is orthopedics. And we have, many times, mentioned the market; that makes that a challenge.

Mr. STEARNS. I will yield to Chairman Stump.

Mr. STUMP. Dr. Lee, you mentioned you were having trouble with getting orthopedic surgeons. Under the bill we passed a year or so ago, the eligibility reform bill, that gives the VA authority to contract out, can you not use that in this case where you can't hire an orthopedic surgeon?

Dr. LEE. That really is intriguing, but we have heard this mentioned many times; if you consider the local marketplace, they are fully and gainfully occupied just with all the private patients they have. So far what we get actually comes from people who feel that they do owe an obligation to veterans. So, no, we can't effectively use that contracting authority just because the marketplace is already saturated.

Mr. STUMP. Thank you.

Mr. TIPPETS. I will just expand on that. We did meet with the orthopedic group on a number of occasions which we used and we tried to expand coverage at the medical center, but quite frankly, they were so busy in their practice that they were not willing to increase their workload.

Mr. STEARNS. We heard from veterans about this waiting time experience, and you know, veterans we are talking about traveling to Portland, Salt Lake City, Seattle, for example. So what you are saying, Dr. Lee, is when you go to a local doctor who has a specialty that is required you contact him, and they say, we don't want your business. Is that what you are telling me they are saying?

Dr. LEE. In essence is what we hear many times. This is a close community and it is a small community. The medical professionals know each other and we work closely together. But despite all of that, most of them have practices that are already largely filled. Quite frankly, because of some arrangements we have, as a patient myself, I can usually get my own patients to see a dermatologist at our facility because of our arrangements and to get in as a private patient. So it varies across the board, but yes, particularly in orthopedics. Orthopedics is the most challenging.

Mr. STEARNS. Let's say, could you, under those circumstances, go somewhere outside the city and contract them to come in because you had that ability and resources too so that people don't have to go to Portland, Salt Lake City, or Seattle? I mean, for a veteran

to do that is an enormous effort. And for this person to say, gee, I can't be served in my own community, and I am a veteran. I think it is a personal affront to him. So, is there a way that you can't go outside and bring these folks back here and temporarily set up some kind of emergency, or at least a general facility, so that these veterans would not have to go these long distances?

Dr. LEE. The challenges of the distance are very real. The nearest facility that has those kind of subspecialists in any proportion are either 350 or 400 miles away and most of those subspecialists, historically, have not been terribly willing to do that. I would defer that question additionally to Dr. Galey to see if he would comment on the larger coastal marketplaces.

Dr. GALEY. What you are actually asking to do is get a physician to come into a fee-for-market service area from one of the areas which has a more competitive environment. Once they have arrived they basically can set up an office here and substantially do better in the same marketplace. So the incentives are not there to attract them to the area.

If you will allow me an anecdote, we are recently trying to recruit a neurosurgeon to one of our facilities, and in talking with me personally one of the people that was in the negotiations asked if they would be interested in a seven-person neurosurgery practice coming over to the VA, and we were told basically that each of the persons in the practice is expected to bill a million-plus a year and if we can play in that league we will be glad to talk to you.

Frankly, we can't play in that league, and so, you know, in those areas where you have a very competitive marketplace, where managed care has penetrated deeply, then we are more able to negotiate a fair price and services for these hard-to-come-by clinicians. In areas like Boise and some of the other rural areas in the northwest network, we have a very difficult time in recruiting.

Mr. STEARNS. Mr. McIntyre mentioned in his opening statement he is having trouble signing up providers. Isn't it possible that the two of you could work together in some way so that a number of these specialties could be available for the veterans and for retired military and dependents? I mean, have you talked to each other at all?

Mr. MCINTYRE. Yes, sir, Mr. Chairman, we are, actually, engaged in a very active dialogue and some of the VA providers are actually part of our network.

The issue that you have been addressing about resource sharing gets to the complicated question of, number one, for us, at least, the licensure issue. Whereas federal programs can use any license in any state we are restricted to only being able to use the licenses of providers in that specific state.

Secondly, you get to the whole reimbursement question. I believe in underserved rural communities around our country including in Boise, ID, that is a very, very significant problem, and you find the same kind of challenge on the Medicare side as you do with Tricare. And if you don't have a lot of overcapacity in your practice, many providers aren't willing to deliver those services for what the federal rates are.

Mr. STEARNS. Have you talked to Colonel Terriberry about this, because in her comments she stated she could use part-time GI and

EMT providers. It looks like between the veterans and yourself and the Air Force base, the Mountain Home Air Force Base, there certainly could be provided some support here to help out.

Colonel TERRIBERRY. If I could address some of that. Just as an example, the issue of orthopedic care. Our requirement is for about one-quarter of an orthopedic person. So that means about one week out of a month we have a need for orthopedics. We have a client basis to support that.

We began that search over a year ago and we finally just now have found and credentialed and got someone licensed and this individual is an older provider who is trying to slow down his practice, who will be traveling from Florida once a month to come here. And it has taken over a year to find this one individual to support us in basic orthopedics.

Mr. STEARNS. Let me ask Chairman Stump, who is going to leave a little earlier, if he has any questions before we go any further.

Mr. STUMP. Mr. Chairman, I do. I might ask Dr. Galey a question. Doctor, you are well aware that the President submitted a budget proposing to cut VA health care. And in fact, in future years the funding level would remain flat. Given that kind of a budget, do you have the means to achieve substantial savings, management, or whatever to make up for this?

Dr. GALEY. Yes. What you are saying is generally true, but the northwest network has always been one of those where the access has been lower than the rest of the country, so we have been on the receiving end of an increase in dollars over the last several years. We expect that to flatten out somewhat in the out years out to 2002 and we are expected to have a flat budget. So we have been able to increase our funds out here, and as we also work on efficiencies we have been able to redirect funds into other areas.

So at the present, and for the foreseeable future, we have the dollars, I believe, that we need to supply the services that we need to.

Mr. STUMP. Mr. Chairman, I do have one more question, if I may. As Mr. McIntyre mentioned, there is a bill before Congress on Medicare subvention so that Medicare-eligible could be provided care at a VA facility and be reimbursed by Medicare. Would this be enough of a savings to help out in this area if we pass the bill?

Dr. GALEY. It would be helpful. It is not a lot of dollars, though, to be quite frank. We treat a number of category C veterans already and only those category Cs that have never been in the system before will be reimbursed under that. And the dollars as you look at them, though significant, and it will help a little, the help that it will bring, it is not going to do a tremendous amount.

Mr. STUMP. Mr. Chairman, thank you very much, and I apologize to you and the committee and the audience, I do have another commitment in Arizona and I will have to leave shortly, and I thank you.

Mrs. CHENOWETH. Thank you very much, Mr. Chairman, for coming all the way out.

Mr. STEARNS. I have used my time, so next I will turn the questioning over to Ms. Chenoweth.

Mrs. CHENOWETH. Thank you, Mr. Chairman. And again, I want to thank Chairman Bob Stump for flying all the way up here from

Arizona. He never leaves his district. He either goes to work in Washington and goes right back home. So it is a measure of his concern that he would come into Boise, ID and measure the concern that we all have for the veterans here in Idaho.

I also want to say Chairman Stearns flew all the way in from Florida yesterday and will be returning to Florida. So I don't think that there is anyone in the Congress that we could have gotten to demonstrate their very serious and dedicated concern for our veterans and our active service military as well as our retired military.

I have heard some very startling testimony today, and I do want to say that everything that I want to ask I will not—time won't allow it. I do want to say that I think we have assembled right here in this room, right at this panel, the finest brain trust for reaching solutions that we could possibly have, certainly in the northwest, if not nationally. And I would like to see these people work together far more than we have seen happen.

Our problem is that people tend to be building their concerns and their organization on their own, and the bottom line is that we have got to change our focus and make sure that we are executing the delivery of health care to those patients.

I am absolutely shocked by Mrs. Schmidt's testimony; I think we all are. And I think it says an awful lot. Colonel Terriberry's statement that actually we have to see solutions driven by market incentives is absolutely correct. The fact is that Medicare reimbursement rates here in the northwest are lower than any other place in the country; however, we knew that going in. And while I am working very hard to make a change in that situation, and in fact, got it in on one of our bills that passed the House and the Senate, it was vetoed by the president in my freshman year, and we would have brought more parity to the Medicare reimbursement levels for the northwest. That desperately needs to be done, but even the Tricare and Triwest contracts were issued on the basis of those Medicare rates being in place.

So while we would like to accommodate, they have been in place, Mr. McIntyre, for quite awhile, and we do want to accommodate our veterans and our service military through your program. There is a lot to be done in terms of what is going on with Triwest.

We heard testimony today that patients over at Mountain Home Air Force Base are being treated like welfare patients. I don't want welfare patients treated any differently than anyone else, and I don't want our service military being treated as if for some reason they are not the very best that we have in America.

This country cannot be a country of honor if we can't honor our promises, and I feel very deeply about that. I want to ask Mr. Tippets, I was just handed an article from the Smart—it is a publication that is put out to seniors, the Smart Traveler. And in this publication it says that the president has recently signed a bill, which it isn't a bill, but something has happened that affects all veterans. This law states in effect if a veteran has not registered at a Veterans Affairs hospital since October 1, 1996 that on October 1, 1998 he or she will lose all medical benefits for life. Are you aware of this? I wasn't. Could you please explain it to the committee.

Mr. TIPPETS. I am not aware of that article, but what they are referring to is absolutely incorrect; that is misinformation.

Mrs. CHENOWETH. Good. I am very glad to hear that. And so would my colleague, Mike Crapo, be. He was very concerned about that too. He is running for the Senate and has a whole state to cover. He has a whole state to cover and he regrets having to leave, and I do want you and the members and the audience to know that.

Mrs. Schmidt, could you please explain the details with regards to your statement about patients being treated less than what we would expect? Could you give us more detail on that.

Mrs. SCHMIDT. I think it stems from the fact that the doctors are full in the State of Idaho. They get the fees that they want from the commercial policyholders, beneficiaries, when they walk in the door. When they do sign on with Tricare or Triwest to be doctors within our system they are already pretty much full, so to see our patients is almost like a charity case. And I have heard several ladies, I have to say ladies because they are spouses taking their kids to be seen on a referral basis, and told—they watch people come in, check in after they have already checked in, and get seen and when they have asked they go, "Oh, those are our regular customers."

And the whole perception is that, I am not a regular customer. Obviously, I must be a charity case. And they get treated and have to wait longer, and they get treated like they are not a regular paying customer. And that all goes back to what the doctors feel about their reimbursement rates and they all have—and this has been told to me by some doctors in the state—they all have a bad taste in their mouth from CHAMPUS because CHAMPUS wasn't always a well-paying policy either. So a lot of them, I don't know if I want to really take Tricare, but if I do hopefully it is not going to be as bad as CHAMPUS.

So we are just kind of sitting in a hole with very few options with such a limited provider network. It doesn't happen that way on the east coast. They have got HMOs and there is compensation there and HMOs work very well there because everybody is used to the system. But for us the United States military is having to knock the doors down of doctors here in this state, and they don't want them knocked on, they don't want them knocked down for sure because they get their fee for service; they don't have to. So that is basically the story behind that one.

Mrs. CHENOWETH. You know, the fact is that in my younger days I used to be a professional physician recruiter for the northwest, and that was when we had a tremendous national physician shortage. And I was able to recruit doctors into the northwest, not because they were paid as much as they were in the larger, more metropolitan areas, but because of the lifestyle that we offered here in Idaho. It is something you just can't find anyplace else. And so active physician recruitment is something that I am going to be watching very, very carefully. And, you know, it is our understanding that even some of our service military families are having to rely on food stamps, and so to be treated with regards to their health care delivery is shocking to me and it absolutely must change.

Mr. Chairman, I do have some other questions, but I would like to yield back to you and then ask those questions.

Mr. STEARNS. Okay. I have just got a few things. Mr. Tippets, you perhaps heard this dialogue. You might want to comment here. It appears to me that between what you heard there is an opportunity here for leadership and perhaps to bring a solution to what Mrs. Schmidt is talking about and Mr. McIntyre, and then I will follow up a question for him.

Mr. TIPPETS. We, of course, are willing to cooperate with Triwest and also Mountain Home to solve these problems. If we can get data regarding the number of patients that we might see at the VA hospital from Tricare from Triwest, then we can try and recruit physicians to take care of these patients.

Mr. STEARNS. Mr. McIntyre, are you prepared to give the VA specific figures on the volume of services by specialty you would willing to buy from the VA medical facility, such that the VA can determine if it can augment its staffing to meet these Triwest patient demands? Are you willing to provide this?

Mr. MCINTYRE. Mr. Chairman, it has been my understanding that that discussion has already taken place historically, and the fact is that we have a number of specialists already signed up that are within the Boise VA system. We will continue that dialogue, and if there are things that the VA feels that it does not have access to in terms of information, we will gladly provide that.

We have actually had education sessions at the VA facility for their providers on how to serve the beneficiaries under this program and what the details of the program are as early as about 4 or 5 months ago.

Mr. STEARNS. I think as a result of this hearing that when we get back to Washington we will probably have some recommendations, but the seeds are here, I think, to solve some of your problems.

One of the areas that Ms. Chenoweth has talked about is telemedicine. Our committee, Dr. Lee, sent out a recent survey concerning telemedicine, and around the country they are using this, as you know, very successfully. Your response in the survey indicated that you didn't have it in place, but I think you do, don't you? I think that is what the staff shows me, that your survey that you responded to, the application of telemedicine, was not in place. Give me a little background, because I think that is a very innovative way to solve some of these problems, particularly in the rural areas of Idaho.

Dr. LEE. We agree. I think it has tremendous promise, although many attempts at implementation have shown that there are also problems which need to meet surmountable challenges that need to be met.

Since we became a network, which really has not happened all that long ago, we have begun to explore that and we have invested heavily in the infrastructurel which will make it possible. That infrastructure is just now coming into place and since the time of the survey we actually have a number of things that are beginning to take place within the telemedicine realm.

One of the keys among those, which I think is fascinating and I didn't comment about it earlier, is we turned the facility, and one of the community vascular surgeons is very intrigued by his ability to stay contemporary with the University of California and San

Francisco. And he participates in a weekly conference with them upgrading his skills to discussing challenging patients. And I think partly as a result of that opportunity he is comfortable in coming to our facility to provide vascular surgery support, a surgical subspecialty which is in short supply at many other VA facilities our size.

So we have some things going on, vascular surgery is one that I would cite within the network we have already started to send images like epocardiography from facility to facility to get on time, real time communications, some of which have been incredibly critical to patients.

Mr. STEARNS. I think from the information we have it shows that you might be starting it, but that you might be lagging here. I think from when we talked to other districts in the veterans throughout the country that perhaps this is an area you might want to expedite because you are a prime candidate for that.

Dr. LEE. I don't disagree with that. I have had the opportunity to view some of them. They started earlier, but Martinsburg, WV has made excellent use of telemedicine, and I am very struck with the fact that there they have kind of a relationship for many of them having gone to the same medical school. And they have comfort in dealing with each other at each end of the telemedicine communication link.

The other place that I know that this is happening very well is in the upper midwest area where many of those facilities actually have been using telepathology for some time and actually are able to view slides. So I think we wholeheartedly agree as a network, and in fact, have a committee that is very actively working on that. In fact, I participate with that, we agree that we need to increase that and it could help us with many of our challenges in this dispersed area.

Mr. STEARNS. Mr. McIntyre, you and I heard Mrs. Schmidt's testimony. She talked about something that could easily be corrected, and that is the feeling that when she calls Triwest, when the people retire or spouses call for the children there is a feeling that they are cornered, a feeling that they are dealt with in a second class way. She didn't use those words, but the implication is something very easy to see. You just have the people at the end show compassion, and you don't want to be told that you are not sick by someone that is not qualified.

So there are two things that concern me with what Mrs. Schmidt said. One, just the lack of compassion and concern from Triwest when they call; and two, the implication that you are deciding how sick she is with somebody who is not even qualified to do it. I would be interested to see what your comments are.

Mr. MCINTYRE. Mr. Chairman, I appreciate you raising that issue. I too was concerned when I heard that.

Mr. STEARNS. This is very easy to solve.

Mr. MCINTYRE. Yes, sir. I monitor the customer service at each one of our sites on a very regular basis. Part of that monitoring comes in the form of the customer comment cards that come into our service centers and we will be checking on this immediately after this hearing. I am on my way up to the Tricare Service Center.

I will be doing the following: First, we had tried to address what we felt were going to be customer services challenges coming into this process, and we have certainly had some and it is obvious that they are not where they need to be. By the bulk of the people that we hire to work in our service centers are actually themselves beneficiaries of Tricare. It was our view that the best way to be able to deliver customer service is having a customer delivering service to a customer. But we obviously have some challenges there and will be acting on that when we leave.

The second thing is, we, under the contract, have a requirement to determine when someone calls for an appointment whether it is emergent, whether it is urgent, or whether it is routine. And we then go and interact with the military treatment facility providers to determine whether there is space to actually deliver those services. So we are required by the contract to go through asking certain kinds of questions, and it is to help people get in for services in an appropriate time frame. If it is not working right, then we need to do something about that. And, we will be reviewing it.

The perception, however, that I am getting is that when you are required to do this activity, you are trying to make medical determinations about people and setting those aside who should otherwise get treatment immediately and serving them a week or two later. That is not how the program should work, and I do not believe that is how it is working. In point of fact, the primary care manager specifies whether something is an emergency or not.

Mr. STEARNS. I can say from what we heard at the get-together yesterday, we heard some complaints. I am just telling you as an outsider here that you have some problems that I think you should address them, and I think when a constituent calls we don't put them in a category. We say we are committed to take care of them, period.

I think we can solve this problem. I would like you to comment on Mr. McIntyre's response to my question about the VA augmenting its staff to meet both VA and Triwest needs.

Mr. TIPPETS. All I need, like I said, and we really haven't received that yet, is an idea of the volume that we can expect of patients. We can look at that as a business plan, if that makes sense then we can try and recruit.

Mr. STEARNS. It goes back to Mr. McIntyre. Are you committed today to telling Mr. Tippets your volume and are you willing to reveal what you need and sit down in an open forum to try and solve this? Because if you won't do this, then I think what we have is a problem we can't achieve a solution for.

Mr. MCINTYRE. Mr. Chairman, it was my understanding that that information had already been provided, and I will find out who it was provided to and I will personally convey it to Mr. Tippets within the VA system.

Mr. STEARNS. You can't be just general here, you have got to be very specific because he can't make decisions without specific information.

Mr. MCINTYRE. It has been provided, but I am not sure that it has gotten to the right people within the VA system, and I will make sure that it goes directly to Mr. Tippets from me personally.

Mr. TIPPETS. I can assure you that I don't have it.

Mr. STEARNS. Mrs. Schmidt, anything you would like to add? I am going to finish my line of questioning and I am going to let Ms. Chenoweth finish up.

Mrs. SCHMIDT. Thank you very much. I am very surprised I get a chance to speak. But I have been listening to all this discussion and testimony. I feel kind of out of my league here at this table not being a professional person in this arena; however, I am a professional user, and I don't mean that in the drug sense. But what I would like——

Mr. STEARNS. Let me tell you something, you are the customer and, like we say, the constituent, both Helen and I went to work for them and we might be the specialists, but really our response is to take care because they are our employers. In a way, you are the constituent here. You have to be satisfied because our commitment here is to make sure you and others and veterans are taken care of.

Mrs. SCHMIDT. My constituency are military families, so I have to take that pledge on too. But I have a question for you guys. And I don't know if this is not appropriate to ask, but Mr. Stump mentioned that the VA is going to have its funding cut. How, then, can the VA help us if their funding is going to get cut and they are going to get a dilution of people who are now willing to use their system?

Mr. STEARNS. A budget of $42 billion a year, do you think there is some ways to increase efficiency to save money?

Mrs. SCHMIDT. Do you want me to be honest or do you want me to tell you—honestly, in a government agency I haven't seen a government agency yet that is been able to use its money wisely.

Mr. STEARNS. You are answering my question, you know. But at $42 billion a year I am committed and Ms. Chenoweth is committed to make it more efficient, make it more consumer-oriented, and to bring in reform and state of the art technology like telemedicine and do these things so that while we continue to increase the funding at the cost of living, but it is still not keeping up, to solve our problems. Dr. Lee or Dr. Galey, any comments you might have?

Dr. GALEY. The VA health care portion of the budget is $17.3 billion a year. As you know, it is leveled for the foreseeable future, I believe, the year 2002. Within that set of dollars the northwest VISN has been receiving additional funds, so I can really only speak for us. We have been really changing our system. We do have significant numbers of efficiencies who are dropping our unit cost, we are seeing more patients, we are accessing more remote areas, opening ambulatory care sites for primary care and mental health in places where we have never been before. So we are shifting those dollars within the framework that we have to, I believe, be more efficient in our services.

Can we meet all of the services, demands that are out there? Quite frankly, no, we can't. We know from already looking at and talking with veterans that are users now and nonusers, people never used us before, that if we open our doors we will have more demand than we have the dollars and facilities to take care of.

So with the help of Congress and with the help of the people that are working within our system to reorient dollars that we currently have, be more efficient with them, we hope to expand our care to

however many veterans that can most be handled within that dollar framework.

But we are changing, we are becoming more efficient and more effective as we sit here with things like telemedicine and opening new facilities throughout the area we plan on seeing more veterans.

Our first obligation is to the veterans, and when we meet that obligation then we can turn our attention to taking care of some of those individuals within the DOD and Tricare family. We would like to be able to do that more extensively than we can right now, and we are working hard to develop those systems. That is going to take us some skill developing some knowledge base and really understanding this population and what their needs are.

So I think there are opportunities, as you point out, whether we have all the funds we need to do everything that we would like to do, I think that is within your hands and the hands of the administration.

Mr. STEARNS. Anyone else on the panel that would like to comment.

Dr. LEE. Perhaps if I could just comment in passing as well. I think we have put very graphically today that the injury in creating expectations but then cannot be met, and I don't disagree that there probably are still some inefficiencies and historically there were more, but this particular VA, and I think the VA as a nationwide system under Dr. Kaiser's leadership, have worked very hard to try to remove a lot of those inefficiencies. And if you look at system performance in terms of numbers of veterans served, reduction of unnecessary beds, deployment of health care, creation of communities based on patient clinic access points and so on, I think that the system is responding and weeding out a lot of those inefficiencies. But still, I think that demand exceeds capacity in many cases, we have heard that many times today, and I am very concerned about making sure that the resources, the expectations, and the demands are met.

Mr. TIPPETS. Earlier in my testimony I mentioned maybe about a dozen areas where we have increased programs in the last 3 years. This has been done, by the way, with an increase of budget from 1996 to 1997 of a little over 3 percent, an increase from 1997 to 1998 of 5 percent, which isn't a lot more than it takes to pay for the national pay raise every year.

We have made efficiencies. We can make additional efficiencies. Can I continue to take an increase of patients 10 percent a year next year and the year after with that type of budget? No, I don't think I can. And one of the responsibilities we have is providing quality care to the veterans we treat, and we can only treat the number of veterans that I can guarantee we can provide quality of care and I don't think I can continue to do that with the level of budget, quite frankly.

Mr. STEARNS. That is an important point. Ms. Chenoweth?

Mrs. CHENOWETH. Mr. McIntyre, I want to ask you some questions about the kind of providers that you have here. When you bid the contract and were successful in receiving the contract, for Tricare we first issued or appropriated about $7 billion for 16 states for medical care under Triwest?

Mr. MCINTYRE. No, not $7 billion for Triwest, $7 billion for all the care delivered in the entire area by both military and non-military.

Mrs. CHENOWETH. And that was 16 states?

Mr. MCINTYRE. That is correct.

Mrs. CHENOWETH. And since then we have appropriated additional money. Right?

Mr. MCINTYRE. I couldn't speak to the facts on that.

Mrs. CHENOWETH. I can, and we have. Having been involved in the medical administration and physician recruiting, I was very interested in the volume of providers, and so I put my staff on calling the list of providers that were—the list that was provided to us by you or by your office, and I have got to say that as my staff contacted all the providers all but two rated the services from Triwest very poorly. I know that is not good news, but it is devastating news to these receiving medical care.

And the concerns ranged all the way from, of course, what you pointed out and rightly so, the CMAC rates are contingent upon Medicare rates, and we all have to work together to get those raised. But also their concern was no specific coverage outlined. They don't know what is covered and what isn't covered, and they send in claims and months later they may get paid for the claim and then a few weeks later they are asked to reimburse that full amount. I mean, I have documentation here where this has happened in doctors' offices and continual reimbursement problems.

So when they don't have specifics with regards to the coverage, I am sure you have had to do a lot in a year, but nevertheless, you were working with the blues and provided—we are promised provision by them of the network and a lot of help to get this going. The fact is that it is not happening out there, and so I would be happy to provide whatever I can to you with regards to the investigation that I have embarked on, because I share with you the fact I want to make it work, it has got to work.

And I want to ask you and Mr. Tippets, are you aware of the Veterans Administration and Department of Defense health resources sharing and Emergency Operations Act, a law passed in 1982?

Mr. TIPPETS. Yes.

Mrs. CHENOWETH. Okay. Mr. Tippets, this act that passed in 1982 requires that the DOD and the Veterans Administration work together and that contracts such as Triwest be able to utilize the facilities at your marginal cost. And marginal cost is a key element in that law. And that is why I am very interested in seeing the group that we have here together begin to work together.

And so with that in mind, I want to say that I think this hearing ought to just be the beginning of your meeting together, and I will officially ask the committee that if we find it necessary that we send someone from the committee out here to a meeting of this group to begin to come up with identifying the problems that we need to solve back in Congress to make sure that health care is provided and make sure that everyone is working together.

Now, we are dealing with the situation where people get caught up in the process, and we lose focus of the fact that we are not delivering health care. Now, I don't want to be emotional, but the fact

is that these service men and women didn't say, "It's not convenient for me not to go serve." They didn't say, "I am not being paid enough." They didn't say anything to their commander-in-chief about the fact that my wife is expecting a baby and I won't be there for the delivery of my first son or daughter. It is not convenient, ladies and gentlemen, to do what I am asking you to do, but it is absolutely imperative that we give our ultimate best to make the system work. And we work way back in Washington, DC. I cannot be here every day and certainly I can't get these chairmen out here every day.

But, Mrs. Schmidt, I would like you to be involved with meeting and with this group, and then sending back a report to us specifically about exactly what needs to be done to implement the health care delivery system better and quicker. And I don't want to set up another process, I want it reported back to this committee that actually we are beginning to deliver and that people are being satisfied. I want to see the end result, and I thank you very much for your time and your effort and your commitment along with us. And I would ask that you, I know you are busy people, but everyone here is busy, and so I would ask that you stay throughout the majority of the hearing to be able to listen to the rest of the testimony. And I will have other questions, Mr. Chairman, that I will submit in writing. Thank you very much.

Mr. STEARNS. Thank you very much for your time. We will have the second panel now come forward. Gary Bermeosolo, who is administrator, Idaho Division of Veterans Affairs.

Well, we want to welcome you and give an opportunity for your opening statement.

STATEMENT OF GARY BERMEOSOLO, ADMINISTRATOR, IDAHO DIVISION OF VETERANS SERVICES

Mr. BERMEOSOLO. Thank you, Mr. Chairman. Looking at the size of my panel I am reminded of the adage that there is comfort in numbers. I think I am in real trouble here.

Mr. Chairman and members of the committee, my name is Gary Bermeosolo and it is my pleasure to serve the State of Idaho as its administrator of Veterans Services. I want to thank you for coming to Idaho and for your sincere concern for the health care needs of the veterans of our great state.

While there are many issues I could address today, my comments will be focused on the state veterans home program. The citizens of Idaho enjoy three state veterans homes which are shining examples of what past president Ronald Reagan termed new federalism.

The program demonstrates what can be accomplished when both federal and state government are committed to a common cause. Mr. Chairman, while we are proud of our achievements there are steps that should be taken to strengthen and enhance the state veterans home program.

Today, with your indulgence, I will advance four suggestions for your consideration. The first consideration would be that VA per diem payments to state veterans home should be increased. Of the options available to VA for the placement of veterans needing skilled nursing care, the state veterans home program is by far the least expensive. In fact, VA is aware they should be doing more to

offset their fair share of our cost. Consequently, last year we received written assurances from VA that it intends to increase its level of per diem support to an amount equivalent to one-third of the national average cost of providing care in a state veterans home.

We agree with VA's per diem assistance goal and ask that your committee ensure that VA provides the maximum annual increase allowed under Title 38 USC until its one-third goal is attained.

Second, Congress should meet its commitment to fund 65 percent of the construction cost of state veterans home. Mr. Chairman, last year your committee supported an $80 million appropriation for state veterans home construction grant program. We thank you for that support, and we ask that this year you support the Senate appropriation subcommittee recommendation of $90 million.

The Senate subcommittee recommended this amount after noting that there is a backlog of $150 million in priority one projects from fiscal year 1998. We agree with their observation that "this program is a cost-effective means of meeting the long-term health care needs of our veterans."

Three, the methodology for awarding state home construction grants needs to be updated. Idaho is one of many states that have a state home construction grant project pending but cannot forecast when federal matching funds will be available to begin construction. We are currently number 53 on the VA's construction priority list. We remained at number 53 for 3 consecutive years despite the $175 million Congress made available to the program during that 3-year period.

The reason for our failure to advance on the priority list is that under the current system new home construction projects moved to the top of the list, which forces renovation projects such as ours down the list and out of funding range.

State directors such as myself are then faced with the arduous task of convincing our state elected officials to leave state matching funds intact. In some cases for years as we wait for federal matching funds to become available.

Mr. Chairman, in the interest of equity we ask that your committee pursue changes in the way grants are prioritized and awarded in the state home construction grant program. Idaho endorses the approach forwarded by the National Association of State Veterans homes. Requests should be prioritized in the year they are received utilizing current VA needs criteria. Grant requests received in future years should be prioritized in the same manner with the understanding that they will not receive funding until projects submitted in previous years receive funding.

However, a state without a state veterans home, and I might mention there are only three that do not have an application in process, Alaska, Hawaii, and Delaware, should automatically become eligible for funding for its first home regardless of the year its request is tendered.

Four, state veterans homes should play an integral part in VA's plans to expand personal care services to veterans. Today a major health care trend is a provision of personal care services. The inclination is to move away from traditional institutionalized care and

favor providing an array of health care services designed to enable those who wish to remain in their own homes to do so.

The VA has implemented a number of hospital-based and contracted personal care service programs designed to assist aging and disabled veterans to continue to live at home. It stands to reason that the network of 95 state veterans homes in 44 states across our country provides an avenue of opportunity for VA to further develop this concept at reduced costs.

Congress should enact legislation that would require VA to establish a state veterans home based on a personal care service program utilizing a funding formula similar to the one currently utilized in the state veterans home per diem program. State veterans homes such as ours in Idaho could make an immediate impact on reducing the number of veterans being forced to move out of their homes and into health care institutions.

Mr. Chairman, by the end of this decade there will be more than 100 state veterans homes in 47 states. The opportunity for partnering with VA remains a viable and cost-effective solution to many of the health care challenges confronting us today. We must remain committed to sharing the responsibility for meeting the challenge of the caring for America's heroes. Without the integration of all available resources, we will fail to meet our moral obligation and the veteran and other taxpaying citizens will be the ultimate loser. Thank you, Mr. Chairman.

[The prepared statement of Gary Bermeosolo appears on p. 89.]

Mr. STEARNS. You know, I think you sort of reinforced this idea I had of trying to save money in doing things more innovatively. Would you expand on your recommendations regarding the state home personal care service program? I mean, that might be a way to help make it more efficient and at the same time give the veterans personal satisfaction.

Mr. BERMEOSOLO. I would be glad to, Mr. Chairman. Currently the per diem program that the VA has established with the state home program has certainly proved its success. Congress hasn't been able to keep up with construction demands.

Under the current program Congress funds 65 percent of the cost of construction, and then the VA, hopefully, will begin offsetting about one-third of the cost of keeping veterans or caring for veterans in the state veterans home. What we would like to see is to take the same formula and apply it to personal care services. We should be able to build adult day care centers with the 65 percent match with the state coming up with the other 35; that we should be able to contract for services in rural areas; that we should be able to send an aide or a nurse to that person's home to allow that person to stay in that home. Or occupational therapist or physical therapist or a physician, whatever it takes, at hopefully reasonable cost with VA picking up one-third of that cost. The other two-thirds would be picked up by the state and by the new federalism, that we have proven works, and by a third party who pays the resident themselves.

Mr. STEARNS. What is the implication of the state homes receiving per diem payments below the one-third level that you recommend?

Mr. BERMEOSOLO. Mr. Chairman, what that means is that the cost of offsetting that care has to come from someplace. So either the state has to pick it up or the cost is passed on to the veteran. In an ideal world I suppose you would have one-third, one-third, one-third scenario, but that is not the case today. VA is coming closer. This year with their proposed per diem increase and if it goes through will be about 31 percent. So we are getting close in nursing care. However, in domiciliary care we are 10 years away by the VA's own estimate at getting up to one-third. I think they are at about 16 percent right now.

Mr. STEARNS. You heard the testimony of the first panel. I am just curious if you had any comments or suggestions based upon what you heard.

Mr. BERMEOSOLO. Mr. Chairman, I think you are right on. I think that the players to make it happen are right here, or were here, hopefully still are here. And it is going to take an effort, cooperative effort, between all the parties to make it happen.

I do have a concern about VA hospitals treating dependents of veterans or servicemen when veterans are being turned away at the door. I think that will be a hard pill when veterans cannot get services or a spouse can't get treated. I would hope that some provision that veterans are taken care of before we start treating dependents. I think that is a very real problem.

Mr. STEARNS. I think Triwest will work it out so that they could get these physicians and specialties, that would necessarily be in the VA hospital, but would be available in the community to do that. I will yield my time. I am finished with my questions. Ms. Chenoweth.

Mrs. CHENOWETH. Thank you, Mr. Chairman, thank you, Mr. Bermeosolo. It is good to see you again, and I commend you on the good work you have historically done here. We all appreciate that very much. I was very pleased to hear your testimony and the fact that you are also concentrating on outreach in the homes. Having just witnessed my parents dying, the difference between my father leaving us in a long-term nursing facility and my mother who was able to stay at home under the care of hospice was a tremendous difference, and I am so glad to see you looking at that. And I personally am very committed to that, Gary, and want to do all I can to assist you in that because of my personal witness in the difference and patient comfort, even pain management, the whole thing, it was absolutely amazing. And most families are hesitant to embark on that journey with their elderly, but it is one that is very rewarding and one that brings a lot more satisfaction in the comfort of a parent or relative. So again, congratulations, and I want to be kept closely informed on how this is progressing and what we can do to help you.

As you are aware we just passed a bill out of the VA committee that would allow for the construction, the 100 percent of construction costs, on VA cemeteries with the state picking up the maintenance and operation. One of my concerns is that, of course, Idaho is, what, one of 50 states that doesn't have a veterans cemetery within our borders.

Mr. BERMEOSOLO. Only one.

Mrs. CHENOWETH. The only one. And so I have a great commitment to move that ahead and work very hard on making sure that we have got that legislation out of our committee. And I look forward to its success on the House floor, and I will be bird dogging it in the Senate too.

But what are your personal feelings about the willingness of the state to pick up the maintenance and operation of a veterans cemetery here in Idaho? When, I don't say if, when we are successful in getting a site placement and it is moving ahead to construction? We have some sites, one that I am looking at particularly, but I do want to work with you and the service organizations on that.

Mr. BERMEOSOLO. Mr. Chairman, Ms. Chenoweth, the VA has done some surveying of the state in terms of what is needed to care for the veterans adequately in the state which is, as you know, the thirteenth largest and yet when we look at population we are down around 43–44. And being rural as we are it looks like it is going to take three state cemeteries.

They are suggesting that one be built in Pocatello for that portion of the state, of course one in the Boise-Nampa area, and one in Lewiston. The challenge that we look forward to there and that we have there, I should say, is that a 40-acre site based on the VA statistics will run about $330,000 per year to maintain. So we are looking at about a million dollars per year commitment from the state to maintain three state veteran cemeteries.

In the past the commission and the governors of the past have indicated that the number one priority was to care—honor the dead by caring for the living; thus, we have three state veterans homes, and I think that was good. In fact, that is the Veterans of Foreign Wars motto or creed, if you will, honor the dead by caring for the living.

Now we have our three veterans homes, our programs are successful. I think it is time to look onward to cemeteries. We prefer a national cemetery so the feds could pick up the tab. We will have a new governor next year, we will be talking with that governor and exploring the possibility of going forward with the state cemetery and hopefully some day perhaps with three.

Mrs. CHENOWETH. You know, Gary, it is sort of like answering the question, how do you eat an elephant? Well, you do just one bite at a time and in this case one is better than three, and I want to start with one, and then—so our veterans and our veterans' families don't have to look forward to having our veterans who served us so honorably whom we are so proud of having be buried clear over in Roseburg, OR or some place like that.

So I look forward to working with you. We are moving things ahead, and so I would like to be able to see that accomplished, at least when I am in my service in Congress.

So together we will look at that bill. I think you will be pleased. I think you probably already know about the 100 percent construction cost, and together we will work with this governor, our attorney general, and our future governor. Thank you very much.

Mr. STEARNS. Thank you, Gary. Before I call up the next two panels I would like to underscore the importance of hearing from our veterans. We have invited state representatives of the major national veterans' organization to testify today.

I reviewed those statements and they will all become a part of our hearing record today. We are very interested in hearing about the care VA has provided veterans in Idaho and the Pacific Northwest and once we get through with the forum, we will have sufficient time to officials answer the questions which I know my same people will have.

With the understanding that your prepared testimony will be part of the record I would like to dispense with readings of opening statements, if I could. What I would request of each of you is that you provide us with any informal comments you might have about VA care veterans are being provided in Idaho generally and at the Boise VA in particular.

So with that we will have panel number 3 step forward, if you would. We have Mr. Al Lance, the distinguished Attorney General; Ms. Shirley Scofield, Commander of Disabled American Veterans; and Mr. T.C. Brock, Senior Device Commander in panel number 3.

We will just move right to informally hear your comments, if you would. We will start out with the Attorney General, Mr. Lance. We welcome you here, it is a delight to have you, and we look forward to your leadership.

STATEMENT OF ALAN G. LANCE, ATTORNEY GENERAL, STATE OF IDAHO

Mr. LANCE. Thank you very much, Congressmen and Congresswoman Chenoweth. Thank you very much for holding these hearings in Boise. Let me thank you for coming to our state, particularly here in our capital. We appreciate and understand that time is short.

I am here before you today wearing basically two hats, representing the American Legion Department of Idaho as well as the Attorney General of the State of Idaho. In my prepared remarks and testimony, which I understand will be inserted as part of the record, I have outlined our support and what is generally referred to as the GI Bill of Health, which is a study which was undertaken by the American Legion on a national basis which we believe outlines basically a road map for the recovery of the VA system and providing a vitality in the future as we go into the 21st century.

With that, I will confine my remarks now to the office of the Attorney General. We have about 110,000 wartime veterans here in the State of Idaho, and as I mentioned this morning to you informally, we have three veterans homes; one in Lewiston, one in Pocatello, and one here in Boise.

As you may be aware, it was necessary for the State of Idaho to bring a lawsuit against the VA last year. The Spokane VAMC notified Lewiston state veterans home that the VAMC would no longer fill prescriptions for veterans who were residents of Idaho's state veterans home in Lewiston. In July of 1997 the Spokane VAMC reversed itself and said it would furnish the medications to eligible veterans, but would not pay the federal per diem for those veterans in nursing home cost to the State of Idaho.

In September of 1997 the Salt Lake City VAMC advised the state veterans home in Pocatello that it would institute the same misguided policy in Pocatello on or about October 1.

Now, let me point out that these benefits are referred to generally and generically by the general public and by the VA as entitlements. These are part of the deferred compensation package, as I think we all understand. Myself and most of us in this room grew up in a little different environment than the average American male of today. You had six choices, you got drafted, you enlisted, you had a medical deferment for legitimate reasons, you went to jail, or you fled to Canada or England or some place like that and dishonorably avoided military service.

But for those of us who went in we were promised, yes, we are not going to pay you very much money because it is an obligation of citizenship, but you have these deferred compensation packages for the rest of your life if you make it. And one of those is medical treatment for the rest of your natural or unnatural life.

We went to a means testing process a few years ago, the VA did, and so it was no longer you are entitled to medical treatment, you are entitled to medical treatment only if you don't have a farm or ranch or small business, which I think was the beginning of its deterioration of the entire contract that most of us had with the United States of America and its citizens.

Going back to the lawsuit, the prescription benefit section, as you are well aware, is 38 USC, Section 1712, subsection D, which provides for prescription medication. And it has been the law in this country for more than 30 years.

The per diem payments for state veterans home care are found in 38 USC, Section 1741, which provides for $39.64 per veteran per day, which goes to defray the cost to the State of Idaho, which is approximately $110 a day.

These were, as we perceive it, policy maneuvers by the VA not authorized by you or Congress, an insult to our veterans, and, in my opinion, a national disgrace.

The veteran policy change would have shifted the cost of entitled veterans' health care to the taxpayers of the State of Idaho and to the veterans themselves. We filed suit in federal district court, the VA stalled, attempting to avoid answering the complaint, the VA said it needed more time to study the issue and asked for more time in responding to the complaint. The issue being whether or not the VA should comply with the federal law that had been on the books for 30 years. That position was unacceptable to the State of Idaho and in November of 1997 we obtained a court order requiring the VA to respond to our complaint by December of last year. Meanwhile, in Salt Lake the VA notified the state veterans home in Pocatello that in light of our lawsuit Salt Lake VAMC would not implement its announced policy change similar to that implemented in Lewiston.

In December of 1997 the VA backpedaled. It finally agreed to comply with federal law and announced a new national policy. A memorandum was signed by your secretary of health for the Department of Veterans Affairs, Kenneth Kaiser. And the memorandum states, and it is a pertinent part and I quote: "VA facilities may no longer withhold per diem payments from states because eligible veterans in their state homes receive prescription drugs from the VA." And I applaud Undersecretary Kaiser for making the right decision in light of our lawsuit.

On January 20, 1998 a settlement agreement was reached with the VA and the VA agreed to comply with federal law, providing prescription medication to eligible veterans as the law provides and paying the State of Idaho the per diem rate for the veterans in our state veterans homes.

In addition, it reimbursed the State of Idaho, the veterans home in Lewiston, the $26,863.03 they had deprived us of in terms of the per diem rate. We are gratified that our efforts on behalf of Idaho veterans are paying dividends to all veterans nationwide, but I am perplexed and somewhat disappointed that a lawsuit was necessary in order to force the administration to keep the country's promise to our veterans.

I am unconvinced that the administration is any more committed today than it was in April of 1997. For that reason we stipulated that the lawsuit was dismissed without prejudice, thus preserving the state's right to return to court should the administration attempt to renege on the deal that we cut.

We are encouraged to have you visit our state. We subscribe to the Senator Hatch theory of life, a deal is a deal. And our veterans in this state, as well as within the United States, made a deal when we entered military service, we kept our end of the bargain and we would appreciate it if the United States Government would keep its. Thank you very much.

[The prepared statement of Alan Lance appears on p. 92.]

Mr. STEARNS. Ms. Scofield.

STATEMENT OF SHIRLEY SCOFIELD, COMMANDER OF DISABLED AMERICAN VETERANS

Ms. SCOFIELD. Thank you. Mr. Chairman and members of the Veterans Affairs Subcommittee on health, on behalf of more than 6,000 members of the Disabled American Veterans, the DAV, the auxiliary and 18 chapters and 10 auxiliary units throughout Idaho, it is an honor and a privilege to appear before you today to discuss the health care issues of this state's service-connected disabled veterans and their families and survivors.

At the outset I wish to thank you and the subcommittee for holding this field hearing and for the support you have given to Idaho veterans and their families and have enhanced our lives during 105th Congress. I want to assure you I did surgery, scissor surgery, on the 10 pages. I have cut mine down to comments, and I hope you don't think they are all negative.

With the downsizing of DOD and VA facilities new cooperative agreements should be reached to enable the two health care systems to function more effectively and efficiently to serve the needs of the members of our armed forces, their dependents, and survivors.

In order to provide greater access to VA health care, medical care savings are being reinvested in patient care by increasing access opportunities through the creation of additional—I am sorry, additional community-based outpatient clinic, COBCs.

Telemedicine, mobile clinics, partnering with vet centers, and the piloting of veterans health resource centers. The DAV has consistently called for and supported a comprehensive VA health care system for entitled veterans. It is our belief that the system should

provide entitlement to guaranteed access to a full continuum of care from preventative through hospice; preserve the VA's mission and role as provider of special services in areas such as blindness, amputation, aging, mental health, and long-term care; maintain an adequate work force of highly skilled and trained health care providers who are adequately compensated; provide a strong and veteran-focused research program.

The DAV further called for enactment of legislation that would promote a broader and greater degree of sharing between health care systems of the VA and DOD by the sharing, but not merging of facilities, staff, and expertise.

The morale of VA health care providers is at an all-time low here in Idaho, and I need to interject that I am in the system, I have interviewed Spokane, WA. I am not speaking for Boise. Spokane is in the catchment area of the northern Idaho for the veterans, and we are actually in a unique state. Our transportation system is a five-state catchment area for the DAV providing transportation to the hospitals for the veterans. The service that we are provided, by the VA hospitals, is Walla Walla, WA; Spokane, WA; the Salt Lake City VAMC; and the Boise VAMC. What I am referring to in my statement and I hope you don't think they are all negative again, I interviewed doctors, I interviewed the administration, and I interviewed the personnel that worked at the hospital before I came here. I have observed—and I have been served there for the last 5½ years.

The outpatient clinics, that is, primary care, optometry, gastrointestinal, orthopedics, ophthalmology, neurology, et cetera are booked out. They are booked out for over 3 months up to 6 months. For some of them it is past the end of the year before you can get an appointment. These delays in treatment are creating health hazards as well as negative health care outcomes and unnecessary deaths, it has even affected malignancies.

The morale of the VA health care providers is at an all-time low here in Idaho and throughout the country. The patient workload continues to rise while VA health care staff are being cut, which leads to an unsafe health care environment.

In addition to patient care delays, physicians and other health care providers are being forced to work 10 to 12 hours a day, and in the nursing/patient ratio within the inpatient and nursing home care units are so compromised that patient safety is compromised. The VA staffing is so inadequate in numbers that veterans often must wait months for clinic appointments for serious medical conditions.

Earlier this month our national commander, Harry R. McDonald, Junior, of Florida wrote a letter to every member of the VA, HUD, and Independent Agencies Appropriations Committee requesting a moratorium on implementing the VA's national formulary of medications, supplies, and health care products. The request was made following hundreds of complaints generated by our members as well as from the VA health care providers. The comments dealt with delays in physicians' abilities to go off formulary due to the clinical needs of the patient. Inferior products as well as the inability of the formulary to keep pace with new products which will improve the patient's preventative and acute needs rather than wait-

ing until a patient is in a chronic and life-threatening health care state.

The members of the DAV Department of Idaho are pleased that both of our representatives, Michael Crapo and Helen Chenoweth and Congressman Clifford Stearns, voted for veterans and to recommit to the conference report. I pledge the DAV's continued support for your efforts.

[The prepared statement of Shirley Scofield appears on p. 98.]

Mr. STEARNS. Thank you very much. Mr. Brock, your comments.

STATEMENT OF T.C. BROCK, SENIOR VICE COMMANDER, VETERANS OF FOREIGN WARS

Mr. BROCK. Thank you, Mr. Chairman. Mr. Chairman and Ms. Chenoweth, it is my distinct pleasure to appear before this subcommittee to represent as a senior vice commander for the Veterans of Foreign Wars, approximately 9,000 members in the State of Idaho. You have, as the Chairman mentioned, my statement and in general summary that statement itemizes the Veterans of Foreign Wars concerns about funding for Veterans Affairs that has decreased considerably from fiscal year 1998 to fiscal year 1999.

Secondly, I would like to mention in passing here that this is a privilege for me because it is my 38th appearance before a subcommittee of the United States Congress. In previous appearances the issues concerned real time intelligence, tactical and strategic development of weapons systems, and military readiness. That was in my past, and in my current position I get an opportunity to defend and help those who used those systems that we developed.

That concern also brings me back to an issue that I heard mentioned several times here, it is a term called efficiency, that we should do things efficiently. My concern is that when you deal with efficiency the word effectiveness is so close behind or loitering about as they might—that we lose sight of the word. Sometimes it is efficient to "do the right job" and that is what it means, to "do the right job." But effective means "do the job right."

The VFW is committed to quality care, and we cannot do that through the VA system if that care is continually degraded and the funding for it is continually decreased. We are, in fact, concerned greatly because—and I in particular just lost a friend, not three weeks ago, to an agent orange issue. He was a Vietnam veteran. My concerns are that the system may have refused him if it had found out, after the current law has passed, that he was a smoker 20 years ago. I get terribly concerned about that because when I was in Vietnam, terribly young and terribly scared, as we all were; I opened a pack of combat rations that fell out of the sky from some angel in green, and in that combat rations packet was a pack of cigarettes.

This Congress has seen fit to eliminate any claims of tobacco-related illnesses that may be filed for our veterans. I noticed that you said this morning you have been through the halls of the VA hospital over here, perhaps you should listen to what you hear as you walk down the halls. They are coughing and they are dying from it. Was it a choice? Sure, it was, but it was also our choice to serve this country. We believed in everything that happened. I was too young to know the difference. Most of those in my same position

were also too young to know the difference. I smoked for 20 years; got out of it at great insistence from my family because I was doing some damage to them too. But there are a lot of folks who cannot quit, a lot of veterans who cannot. We are concerned that there would be a line drawn in the sand that said never again would we consider a smoking related claim. And that is what has happened. It is an outrage, we are concerned.

The Veterans of Foreign Wars would commend this committee for the Medicare subvention issues that are brought up and suggested by this committee. We support those also. Anything we can do to encourage that, we will; as well as our membership.

Secondly, we would encourage on behalf of those retirees from the service the pilot project of the federal employee health benefit program. Let them choose, give them another choice. If everything is not working now, as a federal retiree, I could tell you that 4EHBP is a pretty good program, I like that. Most of my service in the federal system was tied directly to the Defense Department in one form or another.

It is a pleasure to appear before you. I would encourage you to continue the track that you are on. I would encourage you to continue to listen to what the veterans have to say to you. If you can make things right, you are the only voice we have, and we know that. It is a privilege to appear here, it is always a privilege to be involved with the political process. I think every veteran ought to have that feeling at one time to be part of something that works, if we can. If you have any questions I am available.

[The prepared statement of T.C. Brock appears on p. 108.]

Mr. STEARNS. Thank you, Mr. Brock. Concerning your mentioning the tobacco that was dropped in your C rations, and the Attorney General can probably deal with this question better than I can, but the fact that you took the choice to smoke it because it was available, and you might have been bored and were experimenting, our Federal Government should not be encouraging something that now we are prohibiting and we want to tax. I mean, the argument can be made here about the government's responsibility when they gave you free cigarettes time and time again.

Mr. BROCK. In every packet.

Mr. STEARNS. So there is a group of us that felt pretty strong about this, and I have a bill, that states, if there is a settlement by Congress on the tobacco deal that the veterans are entitled to a portion of that settlement. It is not saying anything about taxing, it is not a program creating a bureaucracy, but it is saying if there is a settlement that a portion of this money would go to research and would go to help rehabilitate, to educate, and help people that are in this veterans hospital.

I am happy to say that bill has been introduced and your Congresswoman is on that bill as well as Mr. Stump, and we started that process when we saw the tobacco settlement sort of fall apart because we wanted to make a statement to veterans that we are aware of what happened to you, and we don't think that is right.

I would be curious, perhaps, if any of you have any comments on the testimony of panel 1. You know, I felt within that panel they had the possibility of solving problems we heard yesterday from

more than 200 veterans, and I would be curious if, Ms. Scofield, you have any comments on that.

Ms. SCOFIELD. Thank you. I do have. It would be a layman's solution, the solution for lack of doctors and too many patients, et cetera, you have to change the straight line budget. We cannot inundate the hospitals with more patient care, doesn't matter if it is the military bases or the VA hospital. When we don't have enough doctors and we don't have enough care providers in the hospitals to take care of the patients we have now. I think they need more funds. I know you are working for us, but that straight line budget is going to kill us. We are going to be out on the outside of the hospital waiting to get in and it will kill us.

Mr. STEARNS. You know, I find this very fascinating, here in this state that I hear these complaints. And I am from the State of Florida where we have a huge population increase and more veterans are coming in from the midwest and northeast. And I can understand down there when veterans are complaining facilities are not available or there is a waiting time and so forth, but to hear it here it shows the impact is now moving across countries that are not as densely populated as Texas and California and Florida.

Ms. SCOFIELD. I live in a very rural situation; we have 200 in our town. The VA bus, the mobile clinic, comes through Bonners Ferry, and I have follow-up care there. I listened to the care providers just last Thursday say they [VAMC] are bumping the nonservice veterans from their appointments literally removing the appointment to another 3-month schedule to bring in Tricare patients in order to get the dollars to help fund the hospital. Tell me where the fairness is.

Mr. STEARNS. I want to compliment the Attorney General for his lawsuit. And I guess the question is, why did it take so long? It is a rhetorical question, it is not a question to you personally, because this patient's bill of rights has been around for a long time. In fact, it is posted in the VA medical facility that I was at and I looked at it as I walked through the halls. So I find it troubling, and the question is, are other states starting to understand this or is your state the leader?

Mr. LANCE. Mr. Chairman, I appreciate the question. The VA, as I understand it, was tentatively playing with this little game relative to the state veterans homes, coming out of Washington in my opinion.

Bob Butterworth, your attorney general in Florida, and his staff were talking to the VA when the VA was threatening to implement its policy in the State of Florida, making no progress. I conferred with Bob and his staff and they were very helpful. For some reason the facility in Lewiston was targeted as being the first, in Idaho, at least, to be put under this new experimental policy. Now, possibly the thinking there was a little state like Idaho wouldn't pay much attention, maybe they thought that I didn't have the resources to fight with them, or certainly it should not be the absence of will on my part to fight with them. Anybody that knows me knows better than that.

We told them we would file the lawsuit if they implemented the policy; they went ahead and implemented the policy and we filed the lawsuit the following day. The thing that I find perplexing is

that the United States Code is absolutely crystal clear that the entitlement to receive prescription medication from a facility, VA facility, is not dependent upon where you live, if you live with your uncle, your mother, in a nursing facility that is commercially operated, or a state-run veterans home; the two are independent of one another. That was the point that we were making to them prior to filing the lawsuit, but as I have indicated they chose to ignore us and implemented their policy.

The tremendous impact on the State of Idaho would be that we had the prospect of shifting about $2 million potentially of dollars from the federal budget into the state's budget. And being a small state, as has been observed, $2 million impact on our state legislature might very well have resulted in the closure of one or more of those state-run veterans homes.

Now, since our settlement with them they have also implemented this as a national policy. And I have now heard from about 30-some attorneys general thanking us for our efforts out here in Idaho. It was my privilege to walk point on behalf of attorneys general on this issue and I will do it again if we have to.

Mr. STEARNS. Well, when I see Dr. Kizer I am going to mention it to him. He comes to our hearings often, as you can imagine, and this will be something that certainly seems to me the Attorney General shouldn't have to take the time and resources of their office to protect veterans when that is what the Department of Veterans Affairs is paid to do, and leave the Attorney General to fight some of the local problems, and rather than trying to get the government to do what it should do in the first place.

Ms. SCOFIELD. But thank God they do.

Mr. STEARNS. At any type of hearing I hear a lot of negative things. And God bless Ms. Scofield when she said that. But I generally find there are some things some people are doing right. Is there anything that you could tell me that maybe the VA is doing right here. I really feel it is important to emphasize positive things here too, because I think we have dedicated public officials here, we have people that are trying to make a difference; lack of funding, lack of innovation, whatever it might be. The facility was pretty impressive, all three of them. And the setting is just marvelous. I think both Mr. Stump and I, as well as Ms. Chenoweth were impressed—she has seen it, we have never seen it. I could almost see the cavalry out there 100 years ago. And the flowers and everything are just magnificent. So I don't think I have ever seen that fine a facility as you have here.

Mr. BROCK. Mr. Chairman, with this many folks behind me who are sitting behind me, I can say that the gardener is doing a heck of a job from what it sounds like. Let me also push a little further here and tell you that I believe that this hospital is doing a magnificent job within its resources.

Mr. STEARNS. It is a very clean hospital. We were very impressed.

Mr. BROCK. It is, and I think the staff, from my dealings with them, are doing a magnificent job. What you are hearing here don't confuse with the skill of the staff. I don't think that is the issue, not the skill of the staff. It has to do with the capability to extend that resource until they have run out.

How far can we extend the resource? How long can we take one bucket of water and make this a major pond? That is really a difficult thing to do. I know our service officers; I know the state veterans homes; I have been in all of them and I have visited the VA hospital. I have a number of friends who still reside there. They talk about how effective these people are. They are not only talking about how effective they are in responding to them and they talk about what a good job they do. I don't want that to go away, I don't want anybody in here to give you the impression that we don't believe these people are working hard.

Mr. STEARNS. They are trying.

Mr. BROCK. They are trying. But when you take that amount of money out of a budget and say, okay, let's do a little more with less, as you heard the regional director say, "sure, we are flat for another 3 years, another 4 years, but with other efficiencies we can do it;" I don't doubt that. But we are losing 30,000 World War II veterans a year. That age group, the age group of those veterans is aging faster and there are going to be more and more and more. We are getting to the point where we are going to have to start dealing with long-term care veterans. We are going to have to consider that issue because that age group gets older and older.

It is not a pleasant consideration, but the Veterans of Foreign Wars have watched their membership decline at that rate, and it is mostly World War II vets. But as to looking for negative, the negative is that we are asking them to do maybe too much with too little.

Mr. STEARNS. Okay.

Ms. SCOFIELD. I need to tell you, sir, that the care I received from Spokane has been excellent. I didn't mean to impart that the thing is falling apart out there.

Mr. STEARNS. I understand.

Ms. SCOFIELD. With the population growing and now merging—not merging, but going along with Tricare we are doubling our population to serve, and we don't have enough staff to serve us. [veterans.]

Mr. STEARNS. I think on the first panel we have got a clear idea of what the problems are. So Ms. Chenoweth?

Mrs. CHENOWETH. Mr. Chairman, I do have some questions, but I want to submit them to the committee to be submitted in writing. And I want to thank the members of the panel, three distinguished members.

Mr. STEARNS. Thank you very much for your participation. We will have now panel number 4: Debra Smith, member of the board of directors, National Gulf War Resource Center; Mr. William Woodfin, Commander of the Military Awards of Purple Hearts, Department of Idaho; and Mr. Arthur Boyle, Vice President, Fleet Reserve Association Branch 382. So we want to welcome you here, folks.

We will let you have your opening statements. As I said earlier, I am going to be leaving. It takes me about 9 hours to get back to my home state. I am going to be leaving shortly, probably within about 5 minutes, but I feel very good that I got to this fourth panel and was able to participate and actually it has been a privilege to be here in this wonderful city for the first time and to hear from

distinguished Americans, citizens, and to hear the problems. And I really think your members of Congress, and I and Chairman Stump can make a difference and that is what we are paid to do. So let me open and let you start.

STATEMENT OF DEBRA SMITH, BOARD OF DIRECTORS, NATIONAL GULF WAR RESOURCE CENTER

Mrs. SMITH. I am Debra Smith. Thank you for the opportunity to be here. I am the spouse of a Gulf War veteran, a former marine that served in Operations Desert Shield and Desert Storm. He has become ill. He was ill during the Gulf, he has been rated 60 percent combined service connected.

I am very familiar with the complexities of Gulf War illness, I am on the board of directors of the National Gulf War Resource Center, which is the largest national nonprofit Gulf War veterans' organization based in Washington, DC. With a full-time staff. I also co-founded the Idaho Desert Storm Foundation as a support and referral service for Idaho Gulf War veterans.

My message today is sensitivity in dealing with the Gulf War veterans. This is a new generation of veterans, they are a little bit different than those who served in prior conflicts; they served in one of the most toxic battlefields, one of the most toxic environments ever. I think that the VA needs to use some sensitivity, they need to learn about those battlefields, what happened, what they were exposed to, what the long-term effects can be.

They also need to have some sensitivity in realizing that this was an all-volunteer service, a highly intelligent group of individuals who went to serve in the Gulf War. Sixty percent of them were married. So you are seeing some different problems than you might have perhaps with prior conflict era veterans.

For 5 years the veterans questioned whether they had been exposed to low levels of chemical warfare and for 5 years the Pentagon denied that. In 1996 those denials had to stop because of indisputable evidence clearly defined that veterans had been exposed to low levels of sarin and mustard agents during the destruction of Kamishiyah. The VA needs to understand they need to use sensitivity in learning how these veterans felt so betrayed that their claims for 5 years were denied, then all of a sudden to be turned around and, well, yes, they did happen.

The VA has lacked that sensitivity, they have lacked the sensitivity and understanding that this era of veterans does not understand post-traumatic stress disorder. That diagnosis brings a stigma upon all veterans. The VA has had two or three generations to deal with this and now, once again, they are dealing with it poorly.

Family members need to be included in any mental help therapy that is given. Spouses can be a healing tool, they should not be viewed as a liability by VA care providers.

I find that a lot of our veterans complain of lost medical records. These medical records contain extensive medical histories that are very difficult and sometimes impossible to reproduce. While these medical records are lost veterans' treatment stops until it can be found or replaced or rebuilt. So now you have somebody who's been treated for 16 months, you have to start all over.

Just like Ms. Scofield said, it is the time line. We have veterans who are getting sicker and sicker because they don't have 3 months, 6 months, 9 months to get into a doctor or a consult. I feel that the VA needs case managers for Gulf of War veterans, they need someone to provide an overall management. When you are seeing so many consults, so many test results, so many different appointments this needs to be organized.

Within the State of Idaho a lot of our veterans live in rural communities and must travel great distances to attend VA appointments. Something needs to be done so these veterans aren't traveling two, three, five times a month great distances losing wages, time away and it is hard on their health.

I would ask that the VA use a little more understanding, use a little bit more open mind, don't look in the medical books for the answers, they may not be there. Don't rely on that resource to answer what is causing Gulf War illnesses. Use the veterans themselves, they are the evidence, they have been claiming to be the evidence for 5, 6, 7 years. Here is the kind of incident that should clearly prove that the veterans need to be listened to, they need to be treated with sensitivity, respect, and the dignity that they have deserved by serving our country.

[The prepared statement of Debra Smith appears on p. 114.]

Mrs. CHENOWETH (presiding). Debbie, thank you so much. And the Chairman apologizes for having to leave, but the airplanes don't wait, as you know. That is very compelling testimony, and I have personally appreciated working with you on this issue all the way from working with you on and hearing you and your husband appear before our committee in Washington, DC to washing cars with you to raise money. So a lot of fun to wash cars with you.

The chair now recognizes William Woodfin. Commander Woodfin.

STATEMENT OF WILLIAM WOODFIN, COMMANDER, MILITARY AWARDS OF PURPLE HEART, DEPARTMENT OF IDAHO

Commander WOODFIN. Thank you, Ms. Chenoweth and the distinguished Chairman. It is indeed a pleasure for me to appear before you and give my views concerning the, particularly, the Boise VA medical facility, but also other experiences I have had with the VA through the years.

I am a combat veteran World War II, having served as replacement for the First Infantry Division in 1944. From the date I was wounded in November of 1944 I was moved off the field in Germany and taken to Belgium, France, England and finally to a stateside hospital in Texas. And in December 7, 1945 I was discharged. Most of my experience, of course, has been in the Army hospitals where I obviously received the best of care or I wouldn't be here today.

Moving away from my prepared testimony here for a moment, I have been in major surgery 14 times, and I am proud that I have always tried to keep myself in shape, that I could go through those things. After I was discharged I was rated at 40 percent disability from a chest wound; I was hit with a German grenade and it exploded against my left chest. I used to say I was a freak, but now I say my father in heaven was looking after me.

From 1946 to the present time, some 52 years, I have had the following experiences with the VA: Three exams as a result of my request for a consideration in disability rating increase, testing for aptitude and counseling to attend college under Public Law 16 of the GI bill where I obtained my BS and master's and a little beyond that degree, third was counseling regarding arrangements to make reduced payments on a home loan that I—when I started college was defaulting on and they needed sufficient funds through the aid to maintain my family, my wife and four children.

I was able to get the kind of attention there in the way of funds and guidance that I was able to get my B.S. Degree from a GED in 33 months and moved on; in 18 months, I had my master's. I could not have done that without the—I was under Public Law 16 drawing disability comp with the GI bill.

About 4 years ago I contacted the Boise facility here through the Idaho Division of Veterans Services and under the system of Walter Jackson, one of the service officers in the office of veterans advocacy of the state here, I was evaluated upwards to 60 percent rating. That increase was the cause of PTSD, and I had always found it hard to understand why it took the medical community inside the VA, civilian doctors, that long to understand that a man couldn't be shot at hourly every minute, live in a hole, taste powder cordite, as they called it, how you could go through the experiences like that and be exactly the same.

And in 1997 the closest I have come to medical care under Veterans Administration, I contacted the Boise facility again for an examination of my hearing. The VA was unbelievably fast in making an appointment for me; I was extremely satisfied with the experiences. I didn't have to get a hearing aid.

You will note, most of my experiences have been mainly for services other than health care. Part, if not most of the times, I need health care in operations I have chosen to use my own medical insurance, specifically Blue Cross/Blue Shield under the FEP program, federal employees program and Medicare. I have done that because I figured that I had paid on those and I would prefer to—many people don't have that good of insurance—and I preferred that the veterans program not be burdened by me when I had some pretty good coverage.

I have had a lot of experience, and this is primarily the reason why I would consider even speaking to you, not having used the hospital so much, but I have had considerable experience since I have been a VFW post commander and district manager, and I have been a chapter commander and first commander of the Department of Idaho military of the purple heart.

Within one year's time I had personally met and talked to these individuals and got—that were qualified—and got them to join the organization. And because of the growth and the state we were able to have a Department of Idaho. Now, I am not bragging about that, I am merely saying that as I met with these people constantly when you are talking with veterans, as I am sure you are aware, they will bring up their personal problems; they are no different from other people. And in dealing with them I have come to realize that the veteran himself, his spouse, his widow, his son or daughter, even talked to one or two grandchildren of a deceased veteran

that wondered if I could tell them how to go about getting a copy of his records or how they could get the medal he had earned, the decoration. I have tried to assist them, not as a service officer, I have always referred them to a service officer who was better prepared to help them. But I have tried to always help them to see simply because they would be confusing when they would try to describe what their problem was. They would say they talked to the VA if they talked to the state, or they would talk about one as if it is the other.

I always tried to explain that you have to be patient with the system because I have had experience with three government agencies in my career. There is a reason why forms and procedures are what they are. It doesn't mean they can't be improved by working in two different agencies. With the Federal Government I was put on committees to try to improve forms and try to make them easier. I have cut some down from 6 or 7 pages to 1 page and did the same job. So it can be done. And that was not my specialty, but I did try to not apologize for the Federal Government. I have had the similar kind of experience in state government, but I did try to get the person to see that whatever this trouble is you have to go to, persevere, help may be coming if you will just not try to fight the system, try to fight what your problem is.

I realize this is deviating from what you asked of me. Incidentally, the letter I received, a copy of it, Mr. Chairman, was your letter, but there was nothing with it that I received from my own channel here that sent that to me to tell me exactly the kinds of things that my colleague and friend and the VFW and others have spoken on. I would like to say amen to the things they have said to you. I am a little more inclined to be complimentary of the VA maybe than some people, but it is partly because of these things that I hope that I have seen that they have done quite well.

I don't find fault, really, with the individuals within the system. Most of them, I think, do a tremendous job. I find some fault—when I was in the system, and I am skipping ahead in my talk here, I may get you and me both confused. In the cases where I have experienced in the negative, that is if at all, was with an older doctor and two different facilities. One in Washington, DC and one right over here. The one I had trouble with here I won't get too much into that I might identify him and I wouldn't want to do that. But he was somewhat retired from one of the military services. And this is a minute point, but it is very important. I had tried to see if they wouldn't award me for an old injury to my neck, and I had surgery removed in four of the veterbrae, enough of it they couldn't touch my spinal cord.

Mind you now, I have not gone to them asking them to give me any care, but I was trying to get my rating up at the same time I got the rating increase for the PTSD. And I said to the doctor, "Doctor, there's one problem," and he had called it a gunshot wound, some of the doctors use to call it wound. He says, "Your complaint was received gunshot wound." I said, "No, sir, I want to see if you can help me get that straight in my records." The thing that may have happened to my neck, and I can't say that it did, but the doctor told me my neck was from an old trauma, my problem was from an old injury. And he asked me if I would been

rearended, and I said, no, sir. And I told him about my getting hit with a grenade.

Pardon me for these personal references, but that is the only way I know how to explain this. And he said, "I don't see what that has to do with whether it was a gunshot wound or whether it was whatever you say." And I said, "Because the explosion of that grenade hitting right under my chin, in the side of my chest, blew my steel helmet, my dog tags, hand grenade here (indicating) in my harness, and one right here where I was hit, two bandoliers of ammunition, and all my clothing off of my upper body." And I said, "My buddies when they were working on me under a blanket said to me, one of them said to the other one he's bleeding in his ears and his nose," I believe is the way it went. And the other one said, "Well, his and—all four of my mouth, my nose, my ears, and my eyes there was some blood." And the other one, the third one, said, "He'll hear you." But I was trying to explain that what they called my wound automatically precluded that they could ever, at least, listen to my plea or my argument that maybe that is when I got that thing. Well, it didn't do a bit of good. I came out with the feeling that his mind was made up before he talked to me. His mind was made up.

I find it real difficult to understand how any medical person could assume that a veteran who has given of his life's blood and selfless enough would try to be bilking the Federal Government out of some dollars and that was the end of it.

Now, I have recently put in, I have got enough faith in the system, that I put in for another examination because my PTSD has, I have always when I talk about my God, my country, my fellow veterans I break down, but that is gotten worse and it is causing me not to rest at night as well. So I put in again, I have got faith in the system, to see what is going to happen. I won't fall out with them if they don't grant it. To me my country is my country. If the government is wrong that makes me fight with more fierceness and make my love of my country greater because the very fact that under the system I am free to say what I want to. That is the most precious thing.

I have had a little discussion with different people in different meetings about some recently started VA programs that I think have much merit. I believe they are worth trying, and I am sure I am going to learn many things. One thing is preventative care by sending medical personnel to, in my case it was Twin Falls, I went down and got an examination. I think that will help if we can begin to get veterans into the system. That was somewhat mentioned, I think, here by the panel, it is pretty hard to hear at times back there, before first panel.

If you can get us into the system to see when things are going wrong and not wait until we are in bad shape from it, I think that eventually is better for the person, is better for the country, and is certainly cheaper, I am sure. There is a PTSD program that is been going for some time, and I haven't had a chance to take advantage of that; I intend to in the very near future. And it is provided, I call it, off base. It is provided in Twin Falls again.

I have heard some on this program that, I think, is innovative. That is the VISN program, if you want to call it a program. It may

be a good thing. I have heard many veterans have said to me that they are not sure. I don't know enough personally to critique it at all, but I have heard some of them voice concerns that it seems to be a little understood, at least by veterans, and that they seem to be somewhat operating—any time that can be a case that can certainly confuse people because you go from one center and you hear one thing and you go somewhere else it is a completely different attitude.

In complying, Mr. Chairman, with the letter, copy of the letter, I received that you had put out about what you wanted here at this hearing. I contacted a dear friend, Nile Jones of Twin Falls, to provide his testimony, and I hope you will have a chance to hear him. Jones is the commander of the Twin Falls DAV chapter, and he is also a member of my chapter of the military purple heart there in Twin Falls. He was wounded at the Chosan Reservoir and was a prisoner of war. He has had much more experience with the VA hospital, the medical side, of it than I have. I hope his views will help complete mine.

In closing, veterans everywhere, not only now but have always looked to our congressional party to provide the support and funding that is necessary to maintain the quality of care veterans deserve. They look to Congress to be the watchdog in this, in order that services provided to veterans truly care for widows and orphans. And that ties over—goes over not only with veterans but those in the armed services now.

A few years back we were them, and a few years hence, I don't guess they like to hear that, they are going to be us. So it is one system. And veterans hope that Congress will bring the pay in benefits and dependent services or services for our independence to acceptable standards. And those veterans, or those service men and women, who are now safeguarding our freedom and that of all those untold nations around the world. They are serving in places that when I was fighting there wasn't such nations; it is a different name, new country.

We must not continue to let them suffer from insufficient funding and inadequate health care for themselves and their dependents. And I happen to personally can tell you that my oldest daughter is a widow of a Marine Corps veteran, and I have been with her to try to get care out of CHAMPUS. I told her quit fooling with it. Spend more burning gas trying to get something out of them, and now I am hearing this from Tricare. And I am very concerned, Mr. Chairman and Ms. Chenoweth, that when we contract out services that the Federal Government once gave, once provided, our state government did, there is a tendency for the profit-making organization to want to do just that. And I say that hopefully apologetically to many concerned who do a good job. But it has been my experience, when I was in Federal Government, that every time we contract something out because someone is saying they can do it better than the federal or state government, I don't buy that, I can't accept that.

[The prepared statement of Commander Woodfin appears on p. 110.]

Mrs. CHENOWETH. I thank you very much, Commander. Your comments speak to the sensitivity that Debbie just spoke about so

eloquently, and I thank you very much, Commander. The chair now recognizes Mr. Boyle.

STATEMENT OF ARTHUR BOYLE, VICE PRESIDENT, FLEET RESERVE ASSOCIATION BRANCH 382

Mr. BOYLE. I would like to thank you for the opportunity to speak before you today. My name is Arthur F. Boyle, and I am the vice president of the Fleet Reserve Association Branch 382, as well as member of the council of the Fleet Reserve Association of the State of Idaho. Virtually all of our 160,000 national and approximately 750 state members as well as their families are registered voters. I served our country during World War II and Korea, I retired from the U.S. Navy on April 15, 1959 as a chief hospital corpsman. After 21 years of service with all of my vascular problems I am rated 60 percent disabled. I have been, and still am, an outpatient of the Veterans Administration Medical Center in Boise. If I have time I would like to elaborate a little bit more on this portion of it.

The treatment I have received has been outstanding throughout the years, including the superb treatment I received when I had a cerebral accident, which is stroke, on May 1, 1991. During that time I was hospitalized and had surgery on my left carotid artery and after had rehabilitative treatment.

My message to this committee is one that is crystal clear to those of us who have served and are now serving our country when called upon where ever that may be.

We have been and are now supported by our families even though when we we're on active duty we may have spent months or years before we saw them again. It is a message of concern and disappointment and, yes, even in some cases even of disgust.

Concern for the lack of access for retired service men and women to VA facilities unless they are destitute or have service-connected disabilities, making it impossible for a large portion of career service men and their spouses to be able to support and use VA hospitals. Disappointment in the cancellation of CHAMPUS and transfer to Medicare at age 65 which is a violation of promises made to us by recruiters as an incentive to reenlist that were made to me and my fellow shipmates when we were solicited by our various branches of service to pursue the military as a just and honorable career.

It is disheartening when we hear that money is not available to make things right and at the same time read about hundreds of thousands of dollars given to foreign nationals that were killed by friendly fire while our own casualties are ignored or the $200,000 tax break given to state taxes for those who have an estate of over $17 million, which may cost the treasury $880 million in revenue in the next 10 years. This is as reported by Molly Ivins, a columnist of the Fort Worth Star Telegram and published in the Idaho Statesman commentary section on June 27, 1998.

In conclusion, even though some demonstration projects are authorized it is hard to accept and disappointing, to say the least, to realize that our Nation can help save the world but is unwilling to care for its veterans who have led her to victory time and time again throughout our history. It seems to care more for a civil serv-

ice worker who may have never seen combat or been in harm's way, it would seem that at least, equal treatment in health care would not be asking too much.

Thank you again for the opportunity to speak before you on behalf of my fellow shipmates and their families and your concern for those of us who have served and are serving at your pleasure.

I would like to go back to the problems that I have. In 1990 I had to have a left femoral artery bypass, I had a stenosis of the artery leading down to my foot; I almost lost my foot. My toes and part of my foot turned cherry red, almost black, and the treatment that I received in the replacement and femoral artery bypass has been great except I have to wear a full-length stocking all the time on my left leg because it helps to keep the swelling down. If I don't do that my leg blooms up just like a great big sausage.

And then in the following year in 1991 is when I had my cerebral accident. I was temporarily treated here in Boise for about 5 hours in emergency, and they said that they were treating me to keep the blood from clotting and they made arrangements, and the following—this happened on a Wednesday—and the following Monday they flew me to Seattle, WA to a Dr. Eamons who was director of surgery at the University of Washington School of Medicine, he performed the surgery with some of his assistants from the classes, I presume.

And then the following year I had a blood clot in my left leg, calf, and while I was hospitalized I could not have had any better treatment. I am still all in one piece. I have PTSD (Post Traumatic Stress Disorder) also. I see my therapist, Dr. Dewey, every 2 weeks in a group session and it has been wonderful, but I still wake up in the morning and my bed looks like a battlefield, it is all torn up. But anyway, if there are any questions you would like to propose to me I would be glad to answer them.

[The prepared statement of Arthur Boyle appears on p. 119.]

Mrs. CHENOWETH. Thank you, Mr. Boyle. Thank you very much. Debbie, I wanted to ask you how much of a role does geography and travel play in the access to treatment for our Persian Gulf veterans?

Mrs. SMITH. I think it plays a large role in the State of Idaho. We are so widespread, of course, I can't address the Boise VA, my husband's treatment comes from Spokane. We are in their catchment. I do know that we have veterans traveling over 3 hours one way to get to a doctor. I also know veterans who have removed themselves from the VA system because they cannot afford to lose that time off of their employment. We have employers who, although the veterans are guaranteed that right to attend appointments, they balk at giving the time off for that.

I see that we need some more outreach facilities, we need some more fee-basis abilities. The programs that are available now I know through the Spokane system it is very hard to get into a neurologist or an ophthalmologist. For optometry they are waiting over 9 months now for an appointment. So I don't know if it is so much the geographical location and the fact that they are understaffed and trying to service so many veterans, but I do know the location of the veterans throughout the State of Idaho inhibits the amount of care that they are able to receive.

Mrs. CHENOWETH. You referenced the fact that spouses should be a healing mechanism, not a liability.

Mrs. SMITH. Right.

Mrs. CHENOWETH. Has the VA treated spouses as a liability in dealing with the Gulf War illnesses?

Mrs. SMITH. In my opinion, yes. And I not only speak for myself but from my association with veterans nationwide. Spouses are not welcomed into the examining rooms. It is a right that the veteran has to have a witness there. They are not at all consulted for the mental health programs or treatments. PTSD is very real and almost every veteran I have ever met, and very little is done to associate physical and mental health and the well-being of your physical health and mental health and how your home life can enhance that. We live with them daily. As this gentleman said, my husband's bed is a battlefield every morning.

Mrs. CHENOWETH. Debbie, you know, I found Mr. Tippets to be a very open and receptive administrator, and I just wonder if you possibly have the time, or if we can help make the time for you to work directly with him on some of those families' situations.

Mrs. SMITH. I would very much enjoy doing that. I think that that is been missing is getting the veterans and/or their advocates involved directly with the administration. I am able to say that Spokane VA hospital has been very open. Mr. Parsvale, Mr. Fobbie, Dory Clark, they open their doors any time that we feel we need to talk. We need to get more veterans to understand that these rights are theirs and they can go in and talk to these people. I would be more than happy to talk with Mr. Tippets.

Mrs. CHENOWETH. I would be very pleased. Do you find that there is an adequate number of case managers available?

Mrs. SMITH. No, I do not and that is something that needs to be addressed.

Mrs. CHENOWETH. Would you stay in touch with me on that?

Mrs. SMITH. I certainly will.

Mrs. CHENOWETH. What are some of the common criticisms that our Gulf War veterans are voicing regarding the treatment of the VA and also what are the positive elements that they are encountering?

Mrs. SMITH. What we see on the positive side is the recognition of the chemical exposures with the recognition of the toxic environments are the care providers are more open to the fact that the answers may not be in the medical book. Many of them still do seek the answers through that, but they are listening a little bit more.

The area that I find that they have enhanced is we were at the Spokane VA recently and they had coloring books and crayons for the children. The VA needs to recognize the fact that these are younger veterans that they are dealing with, they do have families. And many times the families must travel with them, especially if they are traveling overnight or long distances. And I thought that was great that they had those available to the children.

I think the case management would provide the overall overseeing efficiency that the veterans need. If you are being seen by a neurologist, an epidemiologist, or an infectious disease physician they need to be corresponding with one another. I think that that is one major complaint is that these veterans feel that their con-

sulting doctors are not sitting down at a table and discussing their case as a total case management. And occasionally they prescribe medications that may interact with one another because one doctor doesn't know what the other doctor prescribed. I do see that the Gulf War veterans are advancing in their medical care. We have a long way to go.

Mrs. CHENOWETH. As you know this has been a very high priority and no small part because of your efforts as well as your husband's efforts with the committee in Washington. And I want to personally thank you and your husband for all that you have done for Gulf War veterans nationally.

Mrs. SMITH. I would just like to see the system that was set in place to care for these brave men and women of our country to treat them with the honor and respect they deserve.

Mrs. CHENOWETH. Mr. Boyle, as I sit here and listen to your testimony I just listen in awe of everything that you have gone through for this country. And I think you know that our concern is to be there for you as you were for us.

Is there anything else you would like to add for the record, Mr. Boyle?

Mr. BOYLE. No. All I can say is that I have no problems with the VA. There is one, but I understand the reason for it. It was discussed here with the panel that when they make an appointment for you it is at least 4 weeks and maybe 2 months. We had to make an appointment for dermatology and it is going to be October the 30th when I get in to see——

Mrs. CHENOWETH. We are trying to work through those.

Mr. BOYLE. I understand that. Having been in the medical profession I understand the problems.

Mrs. CHENOWETH. Well, you shouldn't have to wait.

Mr. BOYLE. It is money.

Mrs. CHENOWETH. Whatever it is we need to cut through it, and we will do that. Commander, do you have anything you would like to add to the record?

Commander WOODFIN. I have talked too long already, but I have tried to move ahead and I probably skipped some things. Please, some day have someone have a chance to read what I said. And I am not a speaker as you can tell.

Mrs. CHENOWETH. I think you did pretty well.

Commander WOODFIN. Two things: Basically, I would not want to leave the impression that I think all is well with VA. There is a lot of room for a lot of change. I do think they are making some changes and things are getting better from what I gather from other veterans, a lot of those veterans.

I think that most of the problems, if I were to try to think I was smart enough to tell, lying, red tape, prior convictions about the length of time it takes to do something rather than say, let's-do-this-one-a-little-faster attitude, and they have got all too many people because you don't need one that is complacent, in a comfortable place. Most veterans, through administration now the Department of Veterans Affairs, I am sorry, are good, dedicated people and they are doing a good job. We have got to some way get the system to where when a veteran, as any citizen, walks into a doctor's office or a medical facility of any kind, we would say that if a doctor

didn't ask you probably first how you were feeling or have you improved any or what's your complaint, we would think ahead—that is part of bedside manner, I guess. If I was going to my doctor in Twin Falls and he didn't give me that kind of courtesy I would lose faith in him, wouldn't have anything to do with—he could be the best chest surgeon in the world.

We have got to do something to get the people that are enthusiastic about taking care of veterans more to the forefront and try to get those others into some kind of a job where they must wait awhile to retire or kick them out, one or the other.

Mrs. CHENOWETH. Thank you very much. This concludes the formal part of our hearing. And I do want to say that for any of you who have, and all of you, who have offered testimony the record will remain open for 10 days should you wish to add to your testimony or make any corrections.

And I do want to say that we are going to recess this hearing for just 15 minutes, and then we will be hearing from anyone else who wishes to testify in the open mic. We have been here quite awhile, and I am willing to stay as long as it takes to listen to all of you, but I do think that we all need a little break.

I want to thank all of you who have been here and listened to all the testimony. You are welcome to stay should you wish. I know that many of you have obligations, but thank you very, very much for your testimony.

Mr. BOYLE. May I say one thing? It is too bad that information such as the panel put out today and what the committee has discussed, it is too bad that we down here in the lower echelon don't receive stuff like that.

Mrs. CHENOWETH. There will be a hearing record published.

Mr. BOYLE. Will we receive a copy?

Mrs. CHENOWETH. If you would like to receive a copy let us know.

Commander WOODFIN. If I may, just one moment. I do hope you can hear the person I asked to come over. His is a 1-page, less than 1 page.

Mrs. CHENOWETH. I certainly will. I have received a note from counsel, we would like to ask the VA, DOD, and Triwest reps to stay and answer any questions, if you wouldn't mind, please.

So for now the committee will recess for 15 minutes, and we will resume the committee at 10 minutes after 2 o'clock. Thank you.

[Whereupon, at 1:50 p.m., the subcommittee was adjourned.]

APPENDIX

DEPARTMENT OF VETERANS AFFAIRS
Network Director, VISN #19
Mountain Towers, Suite 510
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JUN 25 1998

In Reply Refer To: 10N19
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FAX: (303) 756-9243

Dear Congressional Member:

I want to continue to keep you informed about activities that may affect the veterans you serve. I have enclosed a copy of a letter that we are distributing to a broad range of external Department of Veterans Affairs (VA) stakeholders, including veterans service organizations, state directors of veterans affairs and administrators of veterans affairs. The intent of the letter is to describe the VA's enrollment process as well as the VA Rocky Mountain Network's enrollment coordinators for each of our facilities.

Thank you for your continued support of our nation's veterans. If you have any questions regarding the enrollment process, please contact Michael Swan at 303-639-6994.

Sincerely,

Ken Mafflet, MD

for Terrence S. Batliner, DDS, MBA
Director, VA Rocky Mountain Network

Enclosure

DEPARTMENT OF VETERANS AFFAIRS
Network Director, VISN #19
Mountain Towers, Suite 510
4100 E. Mississippi Ave.
Glendale, CO 80222

JUN 25 1998

In Reply Refer To: 10N19
Telephone: (303) 756-9279
FAX: (303) 756-9243

Dear Stakeholder:

Congress has required that after October 1, 1998, most veterans must be enrolled to receive VA health care services. Congress also expanded the range of medical services that enrolled veterans may receive. Letters will be mailed to veterans from late June through September 1998 to inform them of their initial enrollment in the VA health care system. Veterans may continue to apply for enrollment anytime even after October 1, 1998. This fact sheet is intended to provide you information concerning the enrollment process.

How Many Letters Will be Mailed?

- **The first 100,000 letters will be mailed on or about June 29, 1998, to priority one veterans.**
- **Each week thereafter 500,000 letters will be mailed according to eligibility priority groups.**
- **By the end of the summer approximately 3.5 million letters will have been mailed.**

What are the Priority Groups?

Priority Group 1

- **Veterans with service connected conditions rated 50 percent or more disabling.**

Priority Group 2

- **Veterans with service connected conditions rated 30 or 40 percent disabling.**

Priority Group 3

- **Veterans who are former prisoners of war.**
- **Veterans with service connected conditions rated 10 or 20 percent disabling.**
- **Veterans discharged from active duty for compensable conditions.**
- **Veterans awarded special eligibility classification (38 USC, Section 1151).**

Priority Group 4

- **Veterans who are receiving aid and attendance or housebound benefits.**
- **Veterans who have been determined by VA to be catastrophically disabled.**

Priority Group 5

- **Non-service connected veterans and service connected veterans rated zero percent disabled, whose income and net worth is below the established thresholds.**

Priority Group 6

All other eligible veterans who are not required to make co-payments for their care including:

- **World War I and Mexican Border War veterans.**
- **Veterans receiving care for exposure to toxic substances or environmental hazards while in service.**
- **Compensable zero percent service connected veterans.**

Priority Group 7

- **Non-service connected veterans and non-compensable zero percent service connected veterans with income and net worth above the statutory threshold and who agree to pay specified copayments.**

What Additional Information Will be Available Concerning Enrollment?

- **Frequently asked questions outlining major enrollment questions will accompany the enrollment letters.**
- **Employee handbooks will be provided to assist in staff training.**
- **Benefits booklets will be available to veterans upon request.**

How Will VA Answer Questions From Veterans about Enrollment?

- **Veterans may call the VA National Enrollment Service Center's toll free telephone service at 1-877-222-VETS.**
- **Veterans may call the VA Health Eligibility Center with questions about the Means Test or other eligibility concerns at 1-800-929-8387.**
- **Veterans may call their local VA health care facility for other health-related issues.**

When Will the VA National Enrollment Center be Open?

- **Calls will be taken beginning June 30, 1998.**
- **The center will be open from 8:00am to 8:00pm, Monday through Saturday.**
- **Initially 72 enrollment representatives will be available to field inquiries and this number will grow to 102 during the summer.**

How Will the VA Medical Centers Prepare to Handle Calls?

- **Each VAMC will establish an enrollment center to field calls referred from the National Enrollment Center or the Health Eligibility Center, as well as personal calls from veterans.**
- **Each VAMC will have a voice mail system to record calls after normal business hours.**
- **Each VAMC has made a commitment to return calls to veterans by the next business day.**

Who are the Enrollment Coordinators in the VA Rocky Mountain Network (VISN 19)

- **Denver, CO: Charlie Brown, Chief, Ambulatory Care, 303-399-8020 ext. 2300**
- **Cheyenne, WY: Chuck Floyd, Chief, Patient Services, 307-778-7381**
- **Grand Junction, CO: Dennis McMahill, Enrollment Coordinator, 970-242-0731 Pager 6154**
- **Salt Lake City, UT: Lance Robinson, Enrollment Coordinator, 801-584-1200**
- **Sheridan, WY: Kaylene Carlson, Ad Pac Coordinator, 307-672-3473 ext. 3064**
- **Southern CO Healthcare System: Phillip Rivera, Program Support Assistant, 719-384-3134 ext. 3366**
- **VA Montana Healthcare System:**
  Jane Shores, Medical Administration Services, 406-232-3060 ext. 2121 (Miles City)
  Pattricia Warden, Chief Business Officer, 406-447-7651 (Fort Harrison)

Does Enrollment Change the Requirements for Dental, Nursing Home or Non-VA Care:

- **Eligibility for VA's fee basis/non-VA provided care, dental, and nursing home care programs has remained unchanged as a result of Health Eligibility Reform. These benefits are provided under separate statutory authorities than hospital/medical services. For individual cases you should always contact a health benefits advisor at the local VA health care facility.**

What Should You Do?

- **Learn as much as possible about the enrollment process.**
- **Contact the facility enrollment coordinator at any time you have a question or concern.**
- **Refer veterans to the National Enrollment Service Center when they have questions you can't answer.**

As always we want to keep you informed of changes as they occur in our VA health care system. We will continue to provide updates on this as well as other issues. If you have specific concerns please contact our Network Enrollment Coordinator, Mike Swan, 303-639-6994.

Sincerely,

Ken Moffett, MD.

for Terrence S. Batliner, DDS, MBA
Director, VA Rocky Mountain Network

Statement of

Mr. Wayne C. Tippets
Director, Boise VA Medical Center
On the provision of care to Idaho veterans

Before
The House Veterans' Affairs Committee's Subcommittee on Health

June 30, 1998

Introduction

The Boise VA Medical Center is a 68-bed facility with an adjacent 30-bed nursing home serving a Primary Service Area (PSA) with a radius of approximately 160 miles. The PSA covers a service area with a veteran population of approximately 70,000 and includes 23 counties in Southwestern and Central Idaho and four counties in Southeastern Oregon.

Affiliated with the University of Washington School of Medicine, the Boise VA Medical Center is considered the center of academic medicine in Idaho. Staff are extensively integrated with the Southwestern Idaho medical community. The medical education program is composed of 15 full-time faculty members, 52 consulting clinical faculty members, 20 residents in medicine, three to five physicians doing post residency work, and up to 10 medical students at any one time in medical clerkships. Other major affiliations include the Idaho State University College of Pharmacy and Boise State University School of Nursing.

Research plays a vital role in VHA and at the Boise VA Medical Center. A growing team of scientists conduct internationally renowned research in clinical pharmacology, gerontology, and pulmonary and infectious diseases. The fiscal year 1997 research budget totaled $1.6 million dollars and included funds from both government and non-government sources.

Services Provided

The Boise VA Medical Center is a general medical and surgical hospital with a 30-bed nursing home care unit. The Boise VA Medical Center provides acute and intensive care, inpatient medicine, surgery and psychiatry services. Other programs include a mental health clinic, PTSD treatment team, alcohol and drug treatment program, audiology and speech pathology, respiratory care, oncology, ophthalmology, optometry, dental, radiology, nuclear medicine, physical medicine and rehabilitation, prosthetics and sensory aids, and social work services.

The Boise VA Medical Center is tied closely to the healthcare community in Boise and the surrounding area. Through the use of contracts, medical school affiliation, and the VA consultant program, more than 80 professionals from the community provide services to veterans at the VA Medical Center. A sampling of the specialty services provided by these community professionals include; oncology, neurology, dermatology, rheumatology, endocrinology, urology, orthopedics, and, neuro surgery.

The Boise VA Medical Center also purchases local services not available at the VA Medical Center on a fee-for-service basis. Services purchased in the community allow patients to remain in their home environment close to family and support systems. In fiscal year 1997, the Boise VA Medical Center purchased more than $800,000 in services from the local healthcare community.

The VHA is a comprehensive, integrated healthcare delivery system. The Boise VA Medical Center makes use of the comprehensive nature of the VHA by making referrals to tertiary care facilities where patients are able to receive state-of-the-art care that would not otherwise be available at the Boise VA Medical Center. In fiscal year 1998, it is projected that approximately 600 patients will be referred to tertiary care facilities in Seattle, Portland, and Salt Lake City.

Journey of Change

In 1995, The VA Under Secretary for Health, Dr. Kenneth Kizer, articulated the "Vision for Change," a policy for a more efficient and patient centered VA healthcare system. This vision has been implemented across the VA and in Boise by an integrated system of goals, strategic targets, and performance measures. The Boise VA Medical Center has embraced the vision of Dr. Kizer and has been actively pursuing the deployment of resources to better serve our veteran patients by providing a continuum of high quality healthcare in a convenient, responsive, and caring manner. The following data points provide a snapshot of the progress made by the Boise VA Medical Center in achieving Dr. Kizer's vision.

- Decrease Bed Days of Care – VHA is using the Bed Days of Care (BDOC) measure as a proxy for the efficiency of its healthcare system. Reducing BDOC reduces costs and should be accompanied by a concurrent increase in utilization of alternative settings such as ambulatory care. The Boise VA Medical Center has reduced BDOC per thousand users from 2,002 in fiscal year 1995 to 1,467 in fiscal year 1997, a reduction of 27%.

- Decrease Operating Beds – Another measure of efficiency and a key strategy in moving toward a primary and ambulatory care focus is reducing the number of operating beds. The Boise VA implemented programs such as Home Based Primary Care (HBPC), and shifted from inpatient, to a residential care substance abuse program resulting, in a reduction of operating beds from 147 beds in fiscal year 1995 to 98 beds in fiscal year 1998, a 34% reduction.

- Increase Ambulatory Surgery – The common standard of practice is to perform appropriate surgical and invasive procedures in the ambulatory setting thus reducing demand for costly inpatient stays. The Boise VA Medical Center has moved from performing 63% of the designated procedures in the outpatient arena in fiscal year 1995, to performing 79% of the procedures in the outpatient arena in fiscal year 1997.

- Increase Category A Users – One of the strategic targets identified by Dr. Kizer is to increase by 20% the number of healthcare users by the year 2002. The Boise VA Medical Center has actively pursued this goal by establishing mental health clinics in both Twin Falls, Idaho and Ontario Oregon. We are currently planning for the establishment of a Community Based Outpatient Clinic in Twin Falls (September 1998) and in recent years have initiated Health Screening Clinics and annual "Flu" (influenza immunization) Clinics in more remote regions of the Boise VA Medical Center service area. These, and other efforts have resulted in the increase in "Category A veterans" from 9,813 in fiscal year 1995 to a projected 11,138 in fiscal year 1998, a 14% increase. The increase in patients has been accompanied by increases in outpatient visits from 93,455 in fiscal year 1995 to a projected 110,000 in fiscal year 1998, a 17% increase.

Sharing/Revenue Generating Activities

Another of the strategic targets identified by Dr. Kizer is to increase non-appropriated funding sources by 10% by the year 2002. The Boise VA Medical Center is actively pursuing this goal through efforts with sharing agreements, Medical Care Cost Recovery (MCCR), and TRICARE. In fiscal year 1997, the Boise VA Medical Center generated more than $600,000 in revenue through sharing agreements with St. Luke's Regional Medical Center, Idaho State Veterans Home, Mountain Home Air Force Base, and the Elks Rehabilitation Hospital.

The Boise VA Medical Center continues to be a leader in the Medical Care Cost Recovery field. In fiscal year 1997, Boise VA Medical Center staff collected more than 2.7 million dollars from private insurers. In fiscal year 1998 we are projecting collections of over 3.2 million dollars, an increase of 17%.

TRICARE, an approach to meeting military retiree healthcare needs, is an area of increasing interest to the Boise VA Medical Center. In 1997, contracts were signed with Triwest Healthcare Alliance to allow for the provision of medical and surgical care and with Merit Behavioral Care Systems for the provision of mental health care services. To date, services provided have been minimal because of the limited availability of the requested subspecialties at the VA Medical Center. We do however anticipate increasing capacity in the near future that may allow us to be more responsive to TRICARE needs.

Capital Improvements

During the past two years, the Boise VA Medical Center has undergone significant construction and renovation in order to meet the requirements of a state of the art healthcare facility. In 1997, the primary inpatient care area of the Medical Center was completely reconstructed as a combined inpatient medicine and surgery ward. The newly renovated area has resulted in improved patient privacy by eliminating the previous standard six-patient bedrooms in favor of two patient or private bedrooms. In addition, the project eliminated the dilapidated congregate showers in favor of private bathrooms and showers adjacent to each patient room. The project has also resulted in the replacement of the heating, ventilation, and air conditioning systems, resulting in a pleasant environment for our patients and visitors.

Also in 1997, our Outpatient Expansion building was completed, adding 20,000 net square feet dedicated to the delivery of primary care. This project provided space necessary for the enlargement of patient exam and waiting areas and the consolidation of all three of our primary care teams into one area. It also allowed for the location of outpatient pharmacy, laboratory, and the business office functions in the same area, which serves to minimize the need for patients to walk long distances within the medical center.

In 1998 we have completed the renovation of our Canteen (cafeteria). This project has created a comfortable and pleasant atmosphere for our patients, visitors and staff and has enhanced our ability to provide a variety of foods to our customers.

Currently we are in the process of further expanding our primary care capabilities by renovating existing space to create room for a fourth primary care team. This project will be completed in December 1998, and will assist us in meeting the growing demand for primary care at the Boise VA Medical Center.

Patient and Staff Satisfaction

Staff at the Boise VA Medical Center takes great pride in meeting the needs of the veteran patient. This pride is evidenced by the results of the fiscal year 1997 outpatient satisfaction survey administered nationally to over 45,000 veterans by the VA National Customer Feedback Center. Locally, the 175 Boise VA Medical Center patients who were surveyed, rated the Boise VA as a "center of excellence" (defined as a score 2 standard errors better than the national average) in each of the eight survey categories, which include, access, education, preferences, emotional support, visit coordination, overall coordination, continuity, and courtesy.

Staff at the Boise VA Medical Center also rate the Medical Center as a desirable place to work, and the VA as an "employer of choice". In 1993, 1995, and 1998, all staff members from the Boise VA Medical Center were given the opportunity to participate in the Quality System Survey, QSS (also known as the Malcolm Baldrige Survey). The QSS provides an assessment of how employees view the quality culture of the workplace and also the quality of services provided. The Boise VA Medical Center has shown significant improvements with each administration of the QSS. The 1998 survey results showed that the Boise VA surpassed the national VA average in all seven award categories, which include, business results, process management, human resources, information and analysis, customer and market focus, strategic planning, and leadership. The Boise VA Medical Center scored the highest in human resources, the category reflecting employee empowerment and job/employment satisfaction.

Access

A stated objective of VHA is to increase accessibility to services. The Boise VA Medical Center is actively pursuing this goal through a number of innovative programs and activities. In 1997, Boise VA Medical Center staff conducted health screening clinics at several remote sites within the Boise catchment area. Patients from these screening clinics were encouraged to enroll in on-going primary care clinics at the VA Medical Center. Screening clinics are again being planned for fiscal year 1998 and will include additional sites at Salmon, Mackay, and Challis.

The Boise VA Medical Center has received authorization to establish a Community Based Outpatient Clinic (CBOC) in Twin Falls, Idaho. Scheduled to open in September of 1998, the Twin Falls clinic will make available primary care and mental health services to the more than 10,000 veterans that live in the five county area surrounding Twin Falls. The planned CBOC will result in improved access, improved quality of care by promoting more timely attention to medical problems, and reduced operating costs by providing care in an community ambulatory care setting.

Improved access to care is the goal of several other programs and projects at the Boise VA Medical Center, including the DAV van program, HBPC home health program, and high tech/high cost equipment sharing. VA staff, working with the Disabled American Veterans (DAV) service organization, coordinate the efforts of a fleet of transport vans and private vehicles used to shuttle patients to and from outpatient appointments. In the last 12-month period, the DAV van program has logged over 200,000 miles and transported over 3,600 veterans to appointments at the Medical Center.

Home Based Primary Care (HBPC) is another example of a program designed to improve access to care. Through the use of contracted home health professionals, the Boise VA Medical Center home health program is able to arrange and coordinate the care of veterans in even the remote areas of the Boise VA catchment area. The HBPC program is a proven cost effective program for delivering health care and it has been extremely

well received by patients who appreciate receiving healthcare services in their own homes.

A final example of efforts to improve access for Boise VA Medical Center patients is the use of VA programs for the sharing of high/tech, high/cost medical equipment. The Boise VA Medical Center in partnership with St. Luke's Regional Medical Center in Boise, have jointly purchased a linear accelerator for the treatment of cancer patients and a cardiac cath lab for the treatment of heart patients. Having access to this type of technology, that would not traditionally be found at a small VA Medical Center, eliminates the need, in many cases, for patients to travel to a referral hospital and be away from family, friends, and support systems when they are critically ill.

Conclusion

I am extremely proud of the quality of healthcare provided, and the employees who provide this care at the Boise VA Medical Center. There are many unique aspects and characteristics of the Boise VA Medical Center including our interaction with the community hospitals, the integration of private practice physicians who provide care at the VA, and the relationship we have with the Idaho State Veterans Home. There are many challenges facing us in the future and we will be prepared to meet these challenges.

STATEMENT OF

WM. TED GALEY, MD
DIRECTOR, VETERANS INTEGRATED SERVICE NETWORK 20
ON VETERANS CARE IN VISN 20

BEFORE THE
COMMITTEE ON VETERANS' AFFAIRS, SUBCOMMITTEE ON HEALTH
BOISE VETERANS AFFAIRS MEDICAL CENTER
JUNE 30, 1998

Mr. Chairman and members of the Subcommittee, welcome to the Northwest Network. The Northwest Network (NWNW), VISN 20, covers the states of Alaska, Oregon and Washington, and most of the state of Idaho (Exhibit 1.a.). Its six medical centers, one independent domiciliary, one independent outpatient clinic served approximately 115,000 unique veterans (about 10% of the 1.1 million veterans within our geographic area of responsibility) in FY1997. Included within these facilities are 7 nursing home care units, three homeless domiciliaries, and 15 readjustment counseling centers. Six currently approved, 2 currently proposed and 14 planned Community Based Outpatient Clinics (CBOCs) will significantly improve access to northwest veterans and increase the unique patients served between now and 2002 (Exhibit 2).

The Northwest Network has an operating budget of $622M and employs 7300 people. The Network has a research budget of approximately $24M, and is involved in national research programs with the Northwest Health Systems Research & Development program in Seattle, WA, the Environmental Hazards Research Center (Gulf War veteran's illnesses), the Office of Regeneration Research and the newly awarded Center for Rehabilitative Auditory Research at Portland, OR. Further, research, education and clinical care in Mental Health, Geriatrics and Epidemiology are enhanced by a Mental Illness Research, Education, and Clinic Center (Boise, Portland and Puget Sound Health Care System [PSHCS]), a Geriatric Research, Education and Clinical Center (PSHCS), the Oregon Geriatric and Education Center (Portland) and the Epidemiologic Research and Information Center (PSHCS). In support of our education mission, Network facilities have a total of 292 affiliation arrangements with both regional and national academic institutions.

The Network covers approximately 788,500 square miles, 72% of which is the state of Alaska. Most facilities are 150 to 500 miles apart; Anchorage is 2,500 land miles and 1,500 air miles from the nearest VA facility (Exhibit 1 b). The geographic spread, mountainous terrain, and hazardous winter weather conditions offer special challenges for the Network in developing an integrated delivery system.

Mission, Vision and Key Initiatives

The mission of the Northwest Network is to share our resources and talents to produce the best possible outcomes for our patients, the best education for future health providers, and to discover new knowledge. Our vision is to be a leader in the community and in the VA, providing integrated, managed and appropriate care for veterans. We will be a national model for VA networks.

Our major five-year goal is to become an integrated health service delivery system (IHS) providing customer–focused care. An IHS is a network of organizations that provide or arranges to provide a coordinated continuum of services to a defined population and is willing to be held clinically and fiscally accountable for the outcomes and health status of the population served.

Key initiatives in support of our major goal are:

- Implementation of a Primary Care model as the foundation of patient focused health care services.
- Implement a Primary Care Mental Health (MH) model and coordinate MH Services
- Provide a core set of surgical services at each of the Network practice sites
- Improve access to medical specialty services.
- Implement a multi-year plan for development of Community Based Outpatient Clinics (Exhibit 2).
- Develop an integrated information system and process for management of patient information flow (Exhibit 3).
- Implement utilization management measures for ambulatory care services through the Provider Profiling Project/Consumer Health Information and Performance Set (CHIPS).
- Use outcomes measures (Balanced Scorecard & Provider Profiling) to assist in the identification and prioritization of improvement actions (Exhibit 4a).

Now, I will highlight some of these goals and plans to achieve them and conclude with a discussion of the Veteran's Equitable Resource Allocation model and it's effect on the Northwest Network now and in the future.

Primary Care Model

Our plan will rearrange the delivery of primary care services in an effort to make care more patient centered and customer focused. Additionally, we have designed a system that bestows responsibility upon Primary Care Providers for both the quality of medical care and the cost-effective management of resources. We envision a multidisciplinary team approach to delivering care; one that assures continuity with a primary provider as well as other team members over time and location of care. If the Primary Care Teams are to be effective, a number of system changes must occur. The way we provide urgent care, admit patients to the hospital, and obtain specialty consultation will be re-engineered to ensure that Primary Care providers can in fact coordinate care for their patients. It is the reorganization of our delivery system, improving coordination and eliminating redundancy, that will improve the quality and cost-effectiveness of care, and patient satisfaction.

VA owned and operated delivery sites will remain a significant component of our Primary Care Network. To improve access and customer service, however, we will contract with other public and private sector providers, where financially feasible and to the extent allowed by law. The expansion of our Primary Care Network will be planned in a way that controls growth, yet addresses barriers to access. These barriers may be mountain ranges or inner city congestion. The Primary Care Network of the future is likely to be a diverse set of arrangements that create a virtual primary care delivery system, a system that will always deliver value to the veteran.

Coordinated Mental Health Services

Because significant proportions of our clients have mental health concerns, the design of our mental health delivery system is also paramount. We are well along in implementing changes for a system of Coordinated Mental Health Services. We have implemented a multidisciplinary team approach to mental health care. These teams ensure continuity of services throughout the spectrum, from the ambulatory setting through long-term care. Case management of patients with chronic mental illness is the cornerstone of our model. The system changes cited above will also support the role of the Primary Mental Health Provider. Additionally, we have created teams of both psychiatric and medical providers to care for those patients with significant medical problems complicated by chronic mental illness.

Network-wide planning for mental health services will focus on population based resource allocation, shifting care to residential and ambulatory settings, and evaluating a product line management strategy. Northeastern Psychiatric Education Center data suggest that our utilization of acute inpatient services is significantly below the national average. We believe this is, in part, due to the lack of resources in eastern Washington. To correct this, we have recently opened a temporary in-patient psychiatric ward at the Spokane VAMC. We will be building an acute psychiatry ward at the Spokane VAMC with an anticipated opening of April 1999. As a consequence, we anticipate minimal transfer of patients to Boise or the Puget Sound area for acute psychiatric care.

Access to Surgical, Specialty and Ambulatory Care Services

A major challenge for the NWNW is providing access to veterans' health services throughout a relatively sparsely populated large geographic area. With input from stakeholders, attention to population based need, to both VHA and non-VHA resource availability and to maintenance of high value (value = quality + customer satisfaction + economy/efficiency) service availability is being expanded. We are currently implementing plans for core surgical service and core specialty services at all our NWN medical centers. In addition, we are in the process of implementing a multi-year plan for the development of Community Based Outpatient Clinics (CBOCs) (Exhibit 2).

Core Surgical Services: In late 1996 a Surgical Advisor Group (SAG) for the NWNW was appointed and found that many patients were travelling long distances for relatively routine surgical consultation and minor procedures. The SAG defined by specialty a set of services that it thought should be provided locally, if at all possible. The list of specialty services that the SAG recommended should be provided locally included:

General Surgery*	Ophthalmology*
Orthopedic Surgery*	Urology*
Otolaryngology (ENT)	Gynecology
Hand Surgery	

The four specialties indicated by asterisks were ones that were designated to be true "core" services that should be provided locally if at all possible. The SAG recommended that all facilities should ideally be able to offer local consultation and ambulatory procedures in the above specialties. These services could be provided by VA FTEE, by contract or fee-basis arrangements, or by sharing agreements depending on volume of need, cost, and/or availability.

On the other hand, the SAG recommended those patients requiring hospitalization for procedures in the above specialties ought to be referred to VA facilities with in-patient programs because these procedures could be accommodated with existing FTEE and resources. Importantly, these cases are often complex surgeries, are often carried out on patients with multiple co-morbidities and, thus require programs with the volume experience and the extensive support services found only in the major medical centers.

To date, the network has distributed $2.79M to network facilities, including $233K annually recurring and $33K non-recurring funds to Boise, to hire or purchase core services as noted above. With a few exceptions (e.g., Orthopedics in the Boise and Roseburg areas) centers have been able to hire or purchase these services. The results have been to decrease patient travel to receive services, to improve timeliness of services and to decompress the traditionally overcrowded clinics in these specialties in Seattle and Portland, which usually had long waits for new patient tertiary consultation.

Core Medical Specialty Services: In early 1997 an analogous Medical Specialties Committee (MSC) was commissioned to define core medical specialty services for essentially the same reasons as noted for surgical services above. The group identified eight core medical services that if possible should be available locally for ambulatory care, minor procedures and in-patient services within the capability of the available support, technical and professional services. These are:

Audiology	Cardiology
Dermatology	Gastroenterology
Infectious Disease	Neurology
Oncology	Pulmonology

The MSC has recommended that $3.70M recurring funds to be distributed to the facilities for use in the same manner noted above to provide these services locally when possible. This recommendation will be acted upon in the June Executive Leadership Council and it is anticipated that it will be accepted. Boise VAMC is slated to receive $457K annually to accomplish these goals. In the interim tertiary centers have been able to send specialists in some of these fields to the less complex centers and the network has made available funds to hire staff in these specialties prior to ELC approval when good opportunities have become apparent. Both patients and staff have been very pleased with local availability and value of service they have received. Objective measurement of improved service and maintenance of quality will be sought.

Community Based Outpatient Clinics: (See Exhibit 2) Veterans who live in the population centers along the major Northwest Interstate Highways have in general had better access to VHA health services. However, in the more rural parts of the Northwest, which accounts for the bulk of the landmass in this region, veterans often travel great distances, over difficult terrain and often in inclement weather to reach a VHA facility for even basic primary care services.

A major initiative in the NWNW is to develop and put into operation CBOCs that are strategically placed throughout the Northwest. To date a total of six CBOCs have been approved (one in Twin Falls, ID), three are operational and two additional have been proposed and are awaiting congressional clearance. Fourteen are in the planning stages with the intent to activate nine in FY 1999 (one to serve Moscow, ID/Pullman, WA) and five in FY 2000.It is our goal by 2002 to have primary care services available within a 30-mile distance for the majority of Northwest veterans.

Integrated Information System

In August 1997 the NWNW hosted a retreat of nearly 100 multidisciplinary providers, managers and leaders at Bogus Basin, Idaho. The intent was to look at our accomplishments as a network to date and determine the major strategic areas that we needed to focus on to develop an integrated system of health services for veterans. We broke up into groups for a day and came back to present our findings to a plenary session. In each instance the common major need identified for the major elements of an IHS was a user friendly, accurate, fast, accessible information management system. Providers noted a critical need for electronic access to the complete patient record, including consultations and diagnostic studies available anytime and anywhere the patient chooses to access the system. Managers and leaders identified the need for traditional management data and information, but also identified a need for interrelational data base capability. These are crucial to monitor quality, utilization, and stewardship of resources and for the capacity to model systems and their responses to fluctuating variables. Data and information in aggregate, and specifically by provider, by group practices, by unit, etc., are necessary for identifying best and aberrant practice, to monitor efficiency and effectiveness and for professional practice evaluation and improvement.

Finally, the value of Telemedicine Technology was greatly emphasized. The ability to evaluate patients and their diagnostic studies "real time" with discipline specific consultants was noted as an essential for this rural part of the country.

Exhibit 3 is a menu of the developments in information technology and management in the NWNW during FY 1997 and continuing into FY 1998. We have focused on making information systems technology available to our providers throughout the network by providing work stations and access points throughout our systems (Hardware Procurement, Common VISTA Access and Consult Tracking). We have invested heavily in the infrastructure to support the demands of a sophisticated information and communications system (Telecommunication Infrastructure Project, PBX Replacement and Asynchronous Transfer Mode). We are among the national leaders in developing a system wide electronic medical record (Computerized Patient Record System, Network Health Exchange, and Clinical Information Resource Network). We are also among the leaders of all health systems in the implementation and use of Telecommunications and Telemedicine technology (Telemedicine, VISTA Imaging System, and VISN-Wide Videoconferencing System). Lastly, our largest centers and several of our smaller centers are entering current data into the Decision Support System (DSS). This information management and modeling program is a very sophisticated tool to objectively audit and account costs and utilization. It allows evaluation of data sets in numerous ways (DRG Specific, discipline specific, procedure specific, provider specific, group practice specific, etc.) It is also a sophisticated systems modeling tool. The system required that all of the databases be retrospectively built and populated, a several year process which is coming to fruition. The network facilities will be using this data increasingly in management decision-making and change toward more efficient and effective care services.

Provider Profiling (PP), Consumer Health Information and Performance Set (CHIPS) and the Balanced Scorecard (BSC)

The new VHA is an organization of exceptional accountability. The Provider Profiling Project and the Balanced Scorecard are objective measurement and accounting tools that are applied at a provider (practice) specific level or at a system or facility level respectively.

Provider (practice) profiling is an analytic tool that uses epidemiological methods to compare providers on various dimensions by focusing on patterns of care for defined populations of patients over time rather than on individual occurrences of care. Provider Profiling is one of several practice management tools that can be used to improve the quality and efficiency of healthcare. Provider profiling serves several purposes. It serves to link individual performance to organizational performance goals in order to improve the five domains of healthcare value (technical quality, patient satisfaction, functional outcomes, access, and cost). It enables leaders to clarify expectations and performance accountability at the provider and team level. Most importantly, it enables providers and teams to learn about their practices and opportunities for improvement, and facilitates learning and performance oriented culture.

The Balanced Scorecard serves the same purposes for a facility or an IHS that Provider Profiling serves for the provider or practice. In addition, it is balanced because it is constructed in such a way that performance improvement in one area can not be achieved by sacrificing performance in another area. By evaluating the interrelated parts of a system and setting steady state or improvement goals for the component system parts, balanced improvement can be achieved.

Exhibit 3.a. demonstrates the concept of a Balanced Scorecard. Multiple weighted objective measures reside under each of the five domains noted in the left-hand column with **Access** being the first. The relationship between **Access, Cost, Quality, and Satisfaction** is well known with each inexorably linked.

When one is out of balance, too high or too low, one or more of the others suffer. The several elements present under each domain allow for fine-tuning and improvement of the system. This tool allows facilities, or systems to make decisions about where to put various energy levels to achieve specific desirable goals. Examining Exhibit 3.b. for VISN 20 reveals that we perform well against our peers with this methodology, but none-the-less, there are areas like end of life planning and performing Addiction Severity Indices where we need improvement.

On going periodic progress reports are shared with providers, teams and facilities. On a regular basis members of the VISN Executive Leadership Council receive interim data about their performance against these standards. At the ELC the results are examined from the view of an integrated system with the recognition that we are responsible to one another for our collective performance and that our respective performance affects the success of each of the other elements. These tools are used to identify areas for improvements that are data based. The results of action taken can be measured against an objective out come. The system encourages cooperation and support for those elements that are lagging behind and creating issues of performance for the entire organization.

Using this system the NWNW has seen an overall performance improvement of 148%, since FY 1996.

Effect of the Veteran's Equitable Resource Allocation Model On VISN 20

In FY1997, VISN 20 gained 5.96% in resources when compared to FY1996. The uncapped gain should have been 15%, but VERA was delayed for 6 months, and losses were capped by VISN. Four VISNs (1, 2, 3, and 12) lost more than 1.0%, plus they had to absorb inflation for FY1997. Our percent gain was double the national average experience.

In FY1998, VISN 20 gained 4.82% when compared to FY1997. This limited gain was again as a result of the losses being capped in some VISNs. The uncapped gain should have been 8.33%. Nationally, VISN 20 had the 5th highest percent change in resources from FY1997 to FY1998.

FY1999 VERA projections have not been released. We anticipate gaining another 2.5%, if past projections hold. If this FY1999 estimate is accurate, we will have to absorb approximately 2.5% in inflation, plus provide additional services from cost-saving measures.

Summary:

FY1996 Base:	$587	Percent Increase
FY1997 Allocation:	$622 million	5.96%
FY1998 Allocation:	$652 million	4.82%

The increases in VERA have allowed the Northwest Network to increase the number of veterans served by 11% over two years: from 115,228 in FY1996 to a projected 127,960 in FY1998.

As noted above, we have expanded and upgraded outpatient clinics in several facilities, including the Boise VAMC. We have increased availability of surgical subspecialties at several facilities, and established an inpatient psychiatric unit at Spokane. We have invested heavily to upgrade medical equipment such as CT Scanners (Boise's replaced last year), MRIs, and cardiac catheterization units. We have improved information management systems, including fiber optics and servers within facilities, replaced telephone systems, and began implementing computerized medical records. We will be implementing Teleradiology within the Network starting in FY1998. Beginning in FY 98 and extending into FY 1999 we will be investing primarily recurring funds in staff and contracting for services to

provide core medical specialty services in all our medical centers. We will continue to open CBOCs primarily by redirection of existent resources.

Summary

The Northwest Network is becoming an integrated health services delivery system. We are rapidly moving away from a hospital-based system to one based on Primary Care, continuity, collaboration and connectivity throughout the system. We are reorienting our resources to fund information management and communications infrastructure to assist in the smooth flow of veterans and their patient care information through the system. We are increasing access to core surgical and medical specialty services by investing in VA providers and staff or will be purchasing services where it is more economically feasible. We are further increasing access by opening a number of CBOCs in the NWNW and by the development of a Telemedicine capacity to remote sites. We strive to be an accountable health care system, using data, information, and objective measurement of performance and change to continually identify opportunities to improve. With sound management, attention to best practices, and applying Primary Care and VA Care principles of wellness and disease prevention and care management of chronic disease, VISN 20 has the human and financial resources to continually improve the access to and the quality of health services for veterans now and in the foreseeable future. Thank you for the opportunity to address you today.

Exhibit 1a

Northwest Network (VISN 20)

Exhibit 1b

Northwest Network (VISN 20)

Mileage from VISN 20 Facilities to Vancouver Network Office

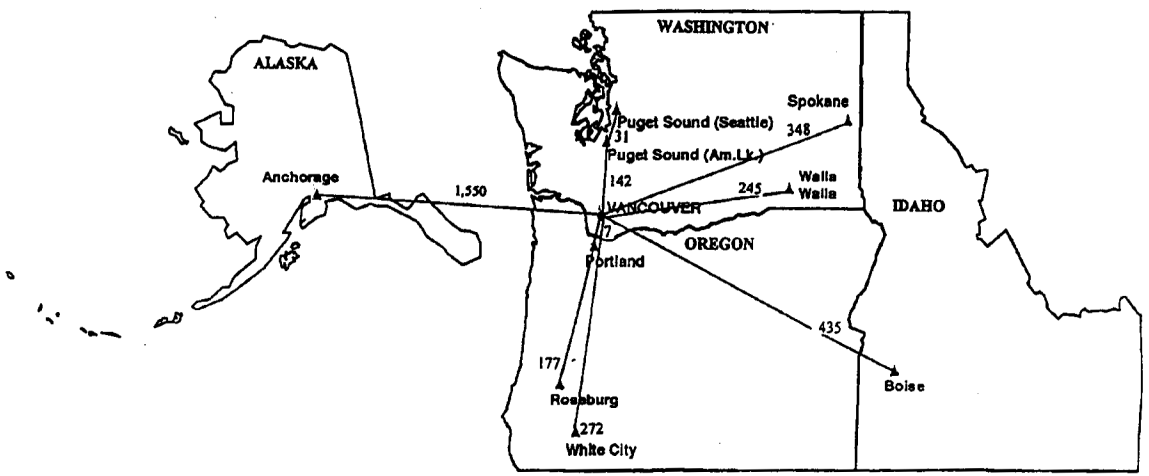


Exhibit 2

COMMUNITY BASED OUTPATIENT CLINICS

Approved

Location	Type	Status
North King Cnty/ South Snohomish Cnty, WA	.Contract	Approved; in negotiation
Salem, OR	Contract M/S & VA-staffed MH	Approved. MH services operational
Bend, OR services	Contract M/S & VA-staffed MH	Approved; MH operational 1/98
Tri-Cities, WA Operational 3/98.	VA-staffed	Approved;
Curry Cnty, OR/Del Norte Cnty, CA	Contract	Approved 2/98
Twin Falls, ID	VA-staffed	Approved 2/98
Longview, WA	Contract	Proposal awaiting next review cycle.
North Coast, OR/South Coast WA	Contract	Proposal awaiting next review cycle.

Planned CBOCs

FY 1999

- Bremerton/Kitsap County, WA
- East Wenatchee, WA
- Moscow, ID/Pullman, WA
- Olympia/South Thurston County, WA
- Yakima County, WA, also serving S. Kittitas County, WA
- Grants Pass, OR
- Klamath Falls, OR
- Lincoln City, OR
- The Dalles, OR

FY 2000

- Beaverton, OR
- Gresham, OR
- Lake Oswego, OR
- Bellingham, WA
- Libby, MT

INTEGRATED INFORMATION SYSTEM

Exhibit 3

In Fiscal Year 1997, we initiated the following programs:

Network Health Exchange (NHEX)

Allows providers to access and review clinical information such as discharge summaries, surgery reports, pharmacy data, and progress notes from a referring facility in the Network.

Common VISTA Access

- Provides clinicians and other appropriate staff with access to patient information at remote facilities in the Network. To date over 450 employees have access to remote facilities through this initiative to enhance patient care activities.

Consumer Health Information and Performance Set (CHIPS)

- Links resource use to outcomes for specific conditions relevant to a particular patient population and provides timely feedback to providers, as well as provider profiling capabilities with case-mix adjustment.

Telecommunication Infrastructure Project (TIP)

- Provides the telecommunication infrastructure to meet the emerging business and clinical information processing needs of the Network.

PBX Replacement

- Provides telephone, video and data system capabilities for integration of network communication connectivity requirements such as state of the art technology, interoperability and compatibility, maintenance, price and consistency.

VISN-Wide Videoconferencing System

- Supports the key communicative elements that foster business and clinical relationship building and communication throughput among the Network partners and customers. The system is used for clinical conferences, telemedicine applications, and administrative support.

Year 2000 Program

- A VISN 20 Year 2000 Program Office that is leading a Network-wide Year 2000 Compliance Program in assessment, renovation, validation/testing and implementation.

In Fiscal Year 1998, we are initiating the following programs in addition to the on-going FY97 initiatives:

Computerized Patient Record System (CPRS)

- Will provide a standard computerized patient medical record system with the capability to enhance access to patient care information and the quality of patient care—full Network implementation by April 1999.

Telemedicine

- Will provide desktop accessibility to clinicians for greater connectivity among providers VISN-wide in support of quality patient care activities such as sub-specialty consulting, home healthcare, and in support of medical education.

VISTA Imaging System (Dyhoff Functionality)

- Will provide radiologic and clinical imaging service functionality VISN-wide that enhances remote access in care of patients.

In Fiscal Year 1999, we plan to implement the following programs:

Asynchronous Transfer Mode (ATM)

- Will allow multiplexing voice, video and data transmissions at higher bandwidth speeds across the VISN's wide area network saving money as technology needs increase with this scaleable connectivity.

Medication Barcode System

- Will provide an information technology system and support to enhance the quality of patient care through the use of medication dispensing technologies at the bedside.

Consult Tracking

Will provide a standardized consultation tracking system to enhance both clinical consultation throughput and the quality of patient care.

Clinical Information Resource Network (CIRN)

- Is the next generation of clinical tools for providers such as the NHEX to access patient information at remote facilities.

Exhibit 4a

1997 Network Director Performance Plan
Part 'C' Measures

Balanced Scorecard -- Overall Score

Domain	Weighted Domain Score (1)	Domain Weight (2)	Score Sum ((1)*(2))/100
Access	64	25	12.25
Quality	25	25	16
Cost	84	25	21
Satisfaction	46	20	9.25
Learning and Growth	65	5	3.25
	Totals	*100*	

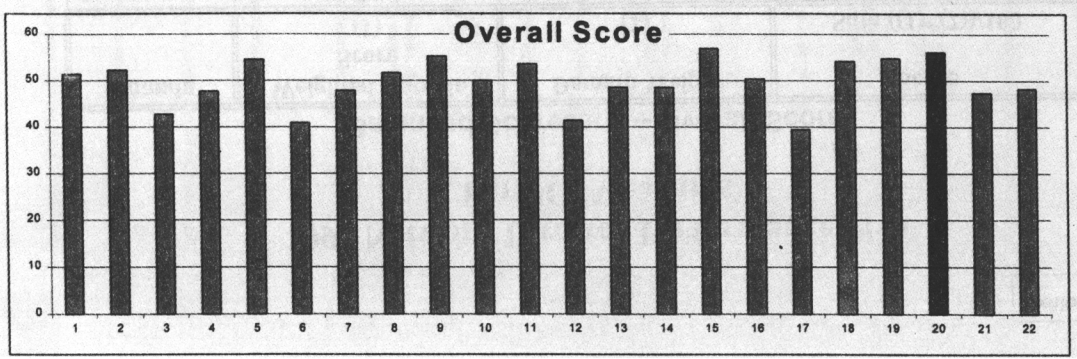
1996 Baseline Score = 25

1997 Final Score = **62** Represents a **148%** improvement

Exhibit 4b

Application of the 1997 VISN 20 Balanced Scorecard to All VISNs

	VISN	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22
Overall Score		51	52	43	48	55	41	48	52	55	50	54	41	49	49	57	50	39	54	55	56	47	48
Inc. Mkt Share		17.5	25	6.25	25	21.25	17.5	12.5	25	22.5	25	6.25	6.25	6.25	6.25	6.25	6.25	6.25	25	6.25	17.5	15	15
Timeliness of Access		15	15	6.25	13.75	13.75	13.75	10	10	12.5	13.75	13.75	15	15	13.75	12.5	10	12.5	13.75	15	15	13.75	6.25
C&P Exams		6.25	6.25	25	6.25	15.75	6.25	12.5	12.5	15.75	6.25	15.75	6.25	6.25	6.25	15.75	15.75	12.5	15.75	15.75	6.25	12.5	6.25
Primary Care Enrollment		6.25	6.25	6.25	6.25	6.25	6.25	6.25	6.25	6.25	6.25	6.25	6.25	6.25	7.5	6.25	7.5	6.25	6.25	6.25	25	6.25	6.25
BDOC / 1000		35	33.25	6.75	35	35	6.75	35	35	35	35	35	6.75	35	35	35	35	22.75	35	35	35	35	35
Total Operating Beds		22.5	21	30	7.5	22.5	15	15	15	22.5	30	30	22.5	22.5	22.5	30	22.5	22.5	22.5	22.5	24	7.5	22.5
Amb Procedures		21	29.75	22.75	24.5	31.5	21	28	28	28	12.25	35	14	19.25	31.5	35	35	6.75	24.5	33.25	24.5	31.5	35
CDI		6.75	6.75	6.75	6.75	6.75	6.75	6.75	6.75	6.75	6.75	6.75	6.75	6.75	6.75	6.75	6.75	6.75	6.75	6.75	6.75	6.75	6.75
PI		6.75	6.75	6.75	6.75	6.75	6.75	6.75	6.75	6.75	6.75	6.75	6.75	6.75	6.75	6.75	6.75	6.75	6.75	6.75	6.75	6.75	6.75
End of Life Planning		2.5	2.5	2.5	2.5	2.5	2.5	2.5	2.5	2.5	2.5	2.5	12	2.5	2.5	2.5	2.5	2.5	2.5	2.5	2.5	2.5	2.5
ASI		5	5	5	5	5	5	5	5	5	5	5	5	5	5	15	5	5	5	5	5	5	5
Preference		3.75	3.75	3.75	3.75	3.75	3.75	3.75	3.75	3.75	3.75	3.75	3.75	3.75	3.75	3.75	3.75	3.75	3.75	3.75	3.75	3.75	3.75
Education		3.75	3.75	3.75	3.75	3.75	3.75	3.75	3.75	3.75	3.75	3.75	3.75	3.75	3.75	3.75	3.75	3.75	3.75	3.75	3.75	3.75	3.75
Emotional Support		3.75	3.75	3.75	3.75	3.75	3.75	3.75	3.75	3.75	3.75	3.75	3.75	3.75	3.75	3.75	3.75	3.75	3.75	3.75	3.75	3.75	3.75
Coordination		17.5	15	13.75	15	15	16.5	12.5	15	16.5	12.5	13.75	16.5	17.5	15	15	13.75	13.75	13.75	17.5	16.25	13.75	12.5
Courtesy		15	11.25	3.75	11.25	3.75	7.5	3.75	7.5	11.25	7.5	7.5	15	15	11.25	3.75	3.75	3.75	7.5	15	15	3.75	3.75
SCI Pt Sat		3.75	3.75	3.75	3.75	3.75	3.75	3.75	3.75	3.75	3.75	3.75	3.75	3.75	3.75	3.75	3.75	3.75	3.75	3.75	3.75	3.75	3.75
Address Mission of VA		31.5	31.5	31.5	31.5	31.5	31.5	31.5	31.5	31.5	31.5	35	31.5	31.5	31.5	35	31.5	35	31.5	31.5	31.5	31.5	31.5
Peer Review Research		15	3.75	3.75	3.75	3.75	15	15	3.75	3.75	11.25	3.75	9.75	15	3.75	15	15	3.75	3.75	15	6.25	3.75	15
Clinical Guidelines		50	37.5	37.5	37.5	50	37.5	50	50	50	50	37.5	37.5	50	37.5	37.5	37.5	37.5	50	50	37.5	50	37.5



TESTIMONY OF COLONEL CYNTHIA A. TERRIBERRY

TO

THE HOUSE VETERANS' AFFAIRS COMMITTEE'S SUBCOMMITTEE ON HEALTH

DISTINGUISHED MEMBERS OF THE SUBCOMMITTEE, I'D LIKE TO THANK YOU FOR THIS OPPORTUNITY TO TELL YOU ABOUT THE CURRENT AND POTENTIAL SHARING ARRANGEMENTS WE AT THE 366TH MEDICAL GROUP AT MOUNTAIN HOME AIR FORCE BASE HAVE WITH THE BOISE VA MEDICAL CENTER. THE VETERANS HEALTH ADMINISTRATION AND THE MILITARY HEALTH SYSTEM HAVE SIMILAR MISSIONS: INCREASING THE HEALTH STATUS OF MILITARY PERSONNEL, VETERANS, AND THEIR FAMILY MEMBERS. CONSEQUENTLY, THE 366TH MEDICAL GROUP AND THE BOISE VA MEDICAL CENTER SEE EACH OTHER AS PARTNERS IN A LONG-TERM RELATIONSHIP, NOT SIMPLY AS ANOTHER ENTITY IN THE HEALTHCARE MARKET PLACE. THERE ARE HOWEVER, SOME VERY IMPORTANT DISTINCTIONS IN OUR MISSIONS AND BENEFICIARY POPULATIONS WHICH IMPACT OUR SHARING OPPORTUNITIES. THE IDAHO HEALTHCARE MARKET IS ALSO A TEMPERING FACTOR IN OUR ABILITY TO SHARE SERVICES. TO EXPLAIN HOW THESE INDIVIDUAL BRUSH STROKES PAINT A COMPLETE PICTURE, I WILL DESCRIBE THE 366TH MEDICAL GROUP'S MISSION AND THE RESOURCES WE HAVE TO ACCOMPLISH IT. NEXT, I'LL USE THE AIR FORCE SURGEON GENERAL'S "STRATEGIC PILLARS" TO ILLUSTRATE WHERE WE ARE HEADED AS WE APPROACH THE 21ST CENTURY. THROUGHOUT, I'LL TELL YOU HOW WE ARE DEALING WITH OUR ISSUES AT THE LOCAL LEVEL. FINALLY, I'LL DISCUSS OUR CURRENT VA SHARING EFFORTS AND OPPORTUNITIES I SEE FOR THE FUTURE.

OUR PURPOSE IS TO SUPPORT THE COMBAT CAPABILITY OF OUR PARENT UNIT, THE 366TH WING. AS YOU KNOW, OUR WING IS THE ONLY STANDING AIR EXPEDITIONARY WING IN THE AIR FORCE. IN TODAY'S WORLD, THIS MEANS WE ARE ROUTINELY TASKED TO DEPLOY TO TROUBLE SPOTS AROUND THE GLOBE. IN THE LAST YEAR, OUR WING HAS DEPLOYED WELL OVER 1,000 TROOPS THREE TIMES: ONCE TO SAUDI ARABIA AND TWICE TO BAHARAIN. IT IS A HUGE TASK TO PREPARE PERSONNEL FOR THESE 90 – 120 DAY DEPLOYMENTS, SUSTAIN THEM ONCE THEY ARE IN PLACE, AND TAKE CARE OF THE TROOPS AND FAMILY MEMBERS LEFT

BEHIND. TO ACCOMPLISH THIS DAUNTING TASK, WE HAVE CRAFTED OUR MISSION STATEMENT AS FOLLOWS: "WE DELIVER A COMPREHENSIVE HEALTHCARE SYSTEM ENSURING READINESS FOR AMERICA'S AIR EXPEDITIONARY WING WORLDWIDE." WHILE IN GARRISON, WE PROVIDE THIS COMPREHENSIVE SYSTEM THROUGH A HEALTH BENEFITS PROGRAM KNOWN AS TRICARE. TRICARE INCLUDES BOTH THE DIRECT CARE WE PROVIDE TO OUR BENEFICIARIES AND THE CARE WE ARRANGE THROUGH A FEDERAL AND CIVILIAN PROVIDER NETWORK. WE HAVE A CONTRACTED BUSINESS PARTNER, TRIWEST, TO HELP US IN THIS ENDEAVOR. WHEN DEPLOYED, WE USE OUR MILITARY PERSONNEL AND VARIOUS CONFIGURATIONS OF OUR AIR TRANSPORTABLE HOSPITAL, OR ATH, TO PROVIDE CARE. WE ALSO USE OTHER MILITARY UNITS OF ALL THREE SERVICES, THE AEROMEDICAL EVACUATION SYSTEM, AND HOST NATION SUPPORT TO COMPLETE OUR "GO ANYWHERE" HEALTHCARE SYSTEM.

AT MOUNTAIN HOME AIR FORCE BASE, WE OPERATE A SMALL, JCAHO ACCREDITED COMMUNITY HOSPITAL WITH 360 MILITARY AND CIVILIAN PERSONNEL. WE ALSO HAVE APPROXIMATELY 35 FULL-TIME EQUIVALENT (FTE) CONTRACTOR PERSONNEL. OUR MAJOR SERVICES ARE PRIMARY CARE, EMERGENCY SERVICES, SURGERY, OBSTETRICS AND GYNECOLOGY, MENTAL HEALTH, AEROSPACE MEDICINE, INTERNAL MEDICINE, PEDIATRICS, PREVENTIVE MEDICINE AND DENTAL SERVICES. WE OPERATE TWO INPATIENT NURSING UNITS, A MULTI-SERVICE UNIT AND AN OBSTETRICAL UNIT, FOR A TOTAL OF 10 AUTHORIZED BEDS. LAST YEAR, WE HAD AN AVERAGE DAILY PATIENT LOAD OF SEVEN AND DELIVERED 330 BABIES. WE PERFORMED 1,771 SURGICAL PROCEDURES ON AN INPATIENT BASIS OR IN OUR AMBULATORY PROCEDURES UNIT. UNLIKE MOST CIVILIAN HOSPITALS, OUR PROVIDERS' MEDICAL PRACTICES ARE LOCATED IN OUR BUILDING AND MANAGED BY US. WE HAVE 12 PRIMARY CARE PROVIDERS. THESE INCLUDE SEVEN FAMILY PRACTICE PHYSICIANS, TWO PEDIATRICIANS, AND THREE PHYSICIAN ASSISTANTS. OUR SPECIALISTS INCLUDE TWO GENERAL SURGEONS, TWO INTERNISTS, THREE OB/GYN PHYSICIANS, AND A PSYCHIATRIST. WE ALSO HAVE TWO GYN NURSE PRACTITIONERS, ONE PEDIATRIC NURSE PRACTITIONER, THREE SOCIAL WORKERS, A PSYCHOLOGIST, A RADIOLOGIST, ONE OPTOMETRIST AND ONE PHYSICAL THERAPIST. WE ALSO HAVE EIGHT DENTISTS

AND TWO EXERCISE PHYSIOLOGISTS. LAST YEAR, WE HAD 88,141 OUTPATIENT VISITS. AS YOU CAN SEE, WE HAVE A SMALL STAFF WITH LARGE RESPONSIBILITIES.

TO BEST GUIDE THE USE OF OUR SHRINKING MEDICAL RESOURCES AIR FORCE-WIDE, THE AIR FORCE SURGEON GENERAL HAS ESTABLISHED WHAT WE CALL THE "STRATEGIC PILLARS." WE USE THESE PILLARS TO GUIDE OUR DAILY EFFORTS AND OUR FUTURE PLANNING. PICTURE A PARTHENON WITH FOUR PILLARS AND A CAPSTONE. THE PILLARS ARE LABELED: READINESS, TRICARE, RIGHTSIZING, AND BUILDING HEALTHY COMMUNITIES. THE CAPSTONE IS LABELED CUSTOMER SATISFACTION.

THE READINESS PILLAR IS JOB ONE AT THE 366TH MEDICAL GROUP. WE REQUIRE 100% OF OUR MILITARY PERSONNEL TO MEET STRINGENT REQUIREMENTS TO MOBILIZE ON A MOMENT'S NOTICE. OVER HALF ARE COMMITTED TO SPECIFIC JOBS UNDER VARIOUS CONTINGENCY PLANS. OVER ONE THIRD HAVE DEPLOYED FOR AT LEAST 45 DAYS IN THE LAST YEAR ALONE. YOU CAN IMAGINE THE EFFORT REQUIRED TO MAINTAIN THIS LEVEL OF READINESS AND TO KEEP ALL SERVICES FULLY OPERATIONAL AT HOME.

IN SUPPORT OF THE SECOND PILLAR, WE IMPLEMENTED TRICARE IN APRIL OF '97. TRICARE OFFERS THREE BENEFIT OPTIONS TO ACTIVE DUTY FAMILIES AND TO RETIRED FAMILIES WHO ARE NOT MEDICARE ELIGIBLE. THE BASIC BENEFIT IS TRICARE STANDARD WHICH IS SIMILAR TO A TRADITIONAL INDEMNITY INSURANCE PLAN. THIS IS THE SAME PROGRAM THAT USED TO BE KNOWN AS CHAMPUS. THERE ARE DEDUCTIBLES AND CO-PAYS WHEN USING A CIVILIAN SOURCE OF CARE. CARE INSIDE THE MILITARY HEALTH FACILITY (MHF) IS FREE, BUT IT IS ON A SPACE AVAILABLE BASIS ONLY. ENROLLMENT IS NOT REQUIRED. TRICARE EXTRA IS SIMILAR TO A PREFERRED PROVIDER ORGANIZATION. IF A BENEFICIARY USES A NETWORK PROVIDER, THEY RECEIVE A DISCOUNTED CO-PAY. ALL OTHER BENEFITS ARE EQUAL TO THE STANDARD OPTION. TRICARE PRIME IS SIMILAR TO A HEALTH MAINTENANCE ORGANIZATION (HMO). WHEN A BENEFICIARY ENROLLS IN PRIME, THEY ARE ASSIGNED A PRIMARY CARE MANAGER (PCM) WHO PROVIDES OR ARRANGES ALL THEIR CARE. THEY RECEIVE PRIORITY FOR APPOINTMENTS, GUARANTEED TIMELY ACCESS, AND GREATLY REDUCED OUT OF POCKET COSTS. IN EXCHANGE FOR THESE BENEFITS, THEY AGREE TO ALWAYS SEEK CARE THROUGH

THEIR PCM. ACTIVE DUTY ARE AUTOMATICALLY ENROLLED IN PRIME. THERE IS AN ANNUAL ENROLLMENT FEE FOR RETIREES AND THEIR FAMILIES.

TRICARE PRIME HAS BEEN VERY POPULAR WITH OUR BENEFICIARIES. WITHIN 90 DAYS, SO MANY OF OUR CUSTOMERS ENROLLED IN PRIME, WE BROKE THE PROJECTIONS OF WHERE WE WOULD BE AT THE END OF 5 YEARS. ACROSS 18 AIR COMBAT COMMAND BASES IN THE UNITED STATES, WE HAVE THE HIGHEST ENROLLMENT OF ELIGIBLE BENEFICIARIES. BECAUSE WE DRAW PEOPLE FROM OUTSIDE OUR DESIGNATED 40 MILE CATCHMENT AREA, WE HAVE ACTUALLY ENROLLED 111% OF OUR CATCHMENT AREA ELIGIBLE POPULATION. THIS IS PARTLY DUE TO THE IDAHO MARKET, BUT IT IS ALSO TESTAMENT TO THE LOYALTY OUR CUSTOMERS HAVE DEVELOPED OVER TIME.

OUR CUSTOMERS' NUMBER ONE COMPLAINT WITH TRICARE IS THAT TITLE X STRIPS THEM OF TRICARE ELIGIBILITY AT AGE 65 WHEN THEY BECOME MEDICARE ELIGIBLE. AT MOUNTAIN HOME, THIS EFFECTIVELY ELIMINATES THEM FROM MILITARY HEALTHCARE BECAUSE OUR SYSTEM IS FILLED WITH PRIME ENROLLEES. CURRENTLY, MILITARY PERSONNEL ARE THE ONLY FEDERAL EMPLOYEES WHO LOSE THEIR EMPLOYER-PROVIDED HEALTH PLAN AT AGE 65. THESE LOYAL AMERICANS WERE PROMISED HEALTHCARE FOR LIFE AS COMPENSATION FOR THEIR DEDICATED SERVICE TO OUR NATION. THIS PROMISE HAS BEEN BROKEN AND THEY KNOW IT. THE SOLUTION IS TO PROVIDE THEM A BENEFIT.

OPERATIONALLY, OUR NUMBER ONE PROBLEM IS OUR CONTRACTED PARTNER, TRIWEST, HAS NOT BEEN ABLE TO DEVELOP AN ADEQUATE CIVILIAN PROVIDER NETWORK FOR US. THERE IS SIMPLY MORE DEMAND FOR MEDICAL SERVICES IN IDAHO THAN THERE ARE PROVIDERS. CONSEQUENTLY, MANY PROVIDERS ARE RELUCTANT TO JOIN OUR NETWORK AND COMMIT TO PROVIDING MORE CARE. THEY SIMPLY DON'T NEED OUR BUSINESS. THIS IS COMPOUNDED BY THE FACT THAT THE CONTRACTOR IS LIMITED TO BARGAINING FOR SERVICES TO THE CHAMPUS MAXIMUM ALLOWABLE COST, OR THE "CMAC" RATE. THESE RATES ARE COMPARABLE TO MEDICARE. LARGE COMMERCIAL INSURANCE CARRIERS IN IDAHO PAY BILLED CHARGES. IN ESSENCE, THE TRICARE PROGRAM ASSUMES THERE IS A COMPETITIVE MARKET – IN IDAHO THERE SIMPLY ISN'T. THE SOLUTION IS TO MARKET-BASE THE CMAC RATES AND TO INCENTIVIZE COMPETITION IN THE MARKET.

THE THIRD PILLAR IS RIGHTSIZING. THE MILITARY DRAWDOWN AND ADVANCES IN MEDICAL TECHNOLOGY HAVE DRIVEN A REDUCTION OF THE AIR FORCE MEDICAL SERVICE. IN 1989 WE HAD OVER 125 FACILITIES WORLDWIDE. TODAY WE HAVE LESS THAN 85. BETWEEN NOW AND 2003, WE WILL REDUCE OUR PERSONNEL ANOTHER 17.9%. MANY HOSPITALS WILL BECOME OUTPATIENT CLINICS. WE DO NOT ANTICIPATE ANY REDUCTION AT THE 366TH MEDICAL GROUP AS LONG AS THE BASE STAYS OPEN. OUR SUBSTANTIAL READINESS TASKING AND ISOLATED LOCATION MAKES IT NECESSARY FOR THE AIR FORCE TO MAINTAIN THE SERVICES WE CURRENTLY HAVE. OUR CHALLENGE IS TO PRODUCE OR ARRANGE FOR SERVICES IN THE MOST EFFECTIVE AND EFFICIENT MANNER. TOWARD THIS END, WE HAVE BEGUN PLANNING FOR A WOMEN'S HEALTH CENTER AND A COMMUNITY COUNSELING CENTER. BY REARRANGING HOW WE USE OUR HOSPITAL, WE BELIEVE WE CAN OFFER STATE OF THE ART SERVICES, INCREASE OUR THROUGHPUT, AND NOT INCREASE OPERATING COSTS. WE HAVE ALSO BEEN DESIGNATED THE DOD BETA TEST SITE FOR A VERSION OF THE CLINICAL INTEGRATED WORKSTATION WHICH WILL AUTOMATE THE PROVIDERS' DESKTOP AND PATIENT HANDLING PROCESS. WE BELIEVE THIS WILL SIGNIFICANTLY ENHANCE OUR ABILITIES BY REDUCING THE ADMINISTRATIVE TASKS OF OUR PROVIDERS AND ALLOW THEM TO SPEND MORE TIME WITH EACH PATIENT.

THE SURGEON GENERAL'S FINAL PILLAR IS BUILDING HEALTHY COMMUNITIES. WE OFFER A VAST ARRAY OF PREVENTIVE MEDICINE SERVICES SUCH AS PUBLIC HEALTH FUNCTIONS TRADITIONALLY DONE BY COUNTY PUBLIC HEALTH DEPARTMENTS; BIOENVIRONMENTAL ENGINEERING; FAMILY ADVOCACY; AND A STATE OF THE ART HEALTH AND WELLNESS CENTER. WE ARE CURRENTLY PREPARING A COMMUNITY HEALTH NEEDS ASSESSMENT SO WE CAN TARGET OUR EFFORTS TO INCREASE THE HEALTH STATUS OF OUR CUSTOMERS.

THE CAPSTONE OF THE PILLARS IS CUSTOMER SATISFACTION. WE HAVE A LONG TRADITION OF PLEASING OUR CUSTOMERS. WE HAVE A COMPREHENSIVE APPROACH TO SYSTEMATICALLY MANAGE HOW WE TREAT OUR CUSTOMERS THAT WE CALL "POSITIVE SERVICE." IT HAS BEEN SO SUCCESSFUL THAT THE AIR FORCE MEDICAL SERVICE DESIGNATED US AS ONE OF FIVE CUSTOMER SERVICE MODEL SITES. AS PART OF THIS PROGRAM, WE HAVE OUR PATIENTS LITERALLY GRADE US ON A CUSTOMER REPORT CARD. THEY RATE OUR SERVICES A, B, C, D, OR F. USING

A TRADITIONAL 4 POINT GRADING SCALE, I'M HAPPY TO REPORT LAST QUARTER WE HAD A 3.7 GRADE POINT AVERAGE. ON DOD SURVEYS, OUR CUSTOMERS CONSISTENTLY RATE US BETTER THAN CIVILIAN HMO CUSTOMERS RATE THEIR HMO. ANOTHER IMPRESSIVE SATISFACTION INDICATOR IS OUR DRAMATIC ENROLLMENT FIGURES I MENTIONED EARLIER.

HOPEFULLY, THIS ALL GIVES YOU AN IDEA OF WHO WE ARE, AND THE CHALLENGES WE FACE. IT IS IMPORTANT TO HAVE THIS OVERALL PICTURE WHEN CONSIDERING THE INDIVIDUAL BRUSH STROKE OF VA SHARING.

WE HAVE A LONG, SUCCESSFUL HISTORY OF SHARING WITH THE BOISE VA MEDICAL CENTER DATING BACK TO THE EARLY 1980'S. OVER THE YEARS WE HAVE PURCHASED NUCLEAR MEDICINE, RADIOLOGY SPECIAL PROCEDURES AND ROUTINE X-RAYS, OUTPATIENT SPECIALTY CONSULTATIONS, INPATIENT PSYCHIATRIC CARE AND A LIMITED AMOUNT OF OTHER INPATIENT SERVICES FROM THE VA. WE HAVE SOLD PHYSICAL THERAPY AND GYN SERVICES TO THEM. TODAY, THE VA IS A TRICARE NETWORK PROVIDER FOR US. THEY PROVIDE SOME MENTAL HEALTH AND MEDICAL/SURGICAL CAPABILITY. LAST YEAR 4% OF OUR TOTAL CUSTOMERS WHO WERE REFERRED TO OTHER FACILITIES FOR CARE WERE SEEN AT THE VA. WE PAID THE VA $92,000 FOR THESE SERVICES. THERE ARE SEVERAL FACTORS THAT KEEP THESE AMOUNTS FROM BEING HIGHER THAN THEY ARE. ONE IS THE VA OPERATES IN THE SAME MARKET WE DO AND THEREFORE, HAS MANY OF THE SAME SHORTAGES OF SOURCES OF CARE WE HAVE. ANOTHER IS DEMOGRAPHIC. OUR POPULATION IS SIGNIFICANTLY YOUNGER THAN THE VA'S. THE MEDIAN AGE OF THE ACTIVE DUTY FORCE IS 28. WE HAVE MANY WOMEN AND CHILDREN CUSTOMERS. CONSEQUENTLY, WE SEEK SOURCES OF CARE WHO ROUTINELY PRACTICE WITH THESE POPULATIONS.

REGARDLESS OF THESE DIFFERENCES, I DO SEE SOME OPPORTUNITIES FOR INCREASED SHARING. WE COULD USE PART TIME PROVIDERS IN ENT AND GASTROENTEROLOGY. IF THE VA HAD CAPACITY, WE WOULD USE IT, BUT HERE AGAIN, THESE SPECIALTIES ARE VERY SCARCE IN THE LOCAL MARKET. IF THE VA HAD PRIMARY CARE MANAGERS WITH CAPACITY TO TAKE NEW PATIENTS, WE COULD ENROLL TRICARE PRIME PATIENTS WHO LIVE IN BOISE TO THEM. ONCE WE COMPLETE OUR COMMUNITY NEEDS ASSESSMENT, WE WILL SHARE IT WITH THE VA. THIS MAY POINT TO OPPORTUNITIES TO POOL THE DEMAND FOR CERTAIN

SERVICES THAT WE COULD JOINTLY DEVELOP. WE MAY ALSO BE ABLE TO OFFER SOME LIMITED SERVICES TO FEMALE VETERANS ONCE OUR WOMEN'S HEALTH CENTER CONCEPT IS FULLY DEVELOPED AND IMPLEMENTED. LASTLY, THERE MAY BE SOME POTENTIAL TO SELL THE LIFE-STYLE-CHANGING SERVICES OF OUR HEALTH AND WELLNESS CENTER TO THE VA.

THANK YOU FOR GIVING ME THE OPPORTUNITY TO MEET WITH THE SUBCOMMITTEE. HOPEFULLY, I HAVE BEEN ABLE TO GIVE YOU AN APPRECIATION FOR THE MISSION, RESOURCES, AND DIRECTION OF THE 366TH MEDICAL GROUP AND HOW IT RELATES TO VA SHARING. MY STAFF AND I LOOK FORWARD TO EXPLORING THESE OPPORTUNITIES WITH OUR VA PARTNERS IN THE FUTURE.

House Committee on Veterans Affairs
Subcommittee on Health
Boise, Idaho Field Hearing
June 30, 1998
Testimony by
David J. McIntyre, Jr.
President and CEO of TriWest Healthcare Alliance

Chairman Stump, Subcommittee Chairman Stearns, and Congresswoman Chenoweth, I would like to commend you for calling this hearing today to review the provision of care to Idaho veterans. In my view, there is no more deserving population than those who have stood in harm's way in defense of our country in its times of need.

My name is David McIntyre. I am President and CEO of TriWest Healthcare Alliance, the TRICARE contractor for the Central Region. We at TriWest, including our Idaho-based owner, Regence BlueShield of Idaho, are honored to have the opportunity to support the Department of Defense as it seeks to meet the health care needs of the more than 700,000 TRICARE beneficiaries that reside in the sixteen state Central Region.

On April 1, 1997, we began offering services to TRICARE beneficiaries in Idaho. Today, TriWest and its subcontractors provide services to more than 24,000 beneficiaries who reside in the State of Idaho. Many of them, in fact, reside in or just outside of the City of Boise where we are meeting today.

As the TRICARE contractor, we are responsible, among other things, for assisting with the marketing of the TRICARE program, enrollment into the HMO-like option of TRICARE, and building and maintaining a network of hospitals and providers to deliver those services that cannot be delivered within the military treatment facilities of the Central Region.

One of the military treatment facilities in our region, in fact the one nearest to where we are meeting today, is located at Mountain Home Air Force Base.

Regence BlueShield of Idaho has subcontracted to undertake our responsibility of building and managing the network of hospitals and providers to support the military treatment facility at Mountain Home Air Force Base. In that capacity, Regence has built a network consisting of civilian providers and Veterans Affairs' providers.

One of the things that has hampered our progress on contracting some specialties in the civilian provider community has been the sufficiency of federal payment rates for these services in and around Boise. For some specialties and services in this area the federal payment rates for both the TRICARE and Medicare programs, which are supposed to be equivalent, fall short of those typically provided by the private sector for the same services. Until this issue is fully addressed, some providers tell us that they are not inclined to join the network. This is an issue we have been working on with the Department of Defense. I am hopeful that the leadership Congresswoman Chenoweth and others have been providing on this issue, particularly with regard to Medicare rates, will result in the needed change.

In addition to working to include civilian providers in the network, we are also working with the Veterans Affairs. Shortly after the award of our contract, we had the occasion to meet with Dr. Ken Kiser, who as you know is responsible for the VA health care system. At that time, Dr. Kiser indicated a strong desire to see us reach out to the VA facilities and providers across our region, as it was his belief that the VA ought to be an integral part of the TRICARE delivery system. We agreed.

Since then, we and our shareholders have contacted numerous VA facilities and providers within our region and invited them to join the network. Just last week I had the occasion

to spend some time with Dr. Kiser and was pleased to inform him, as I am you today, that we now have some thirty VA facilities as a part of the TriWest network, including the Boise VA Medical Center.

I believe that the partnership that has existed between the Departments of Defense and Veterans Affairs for years, and now involves companies like TriWest, is critical for several reasons.

First, it maximizes access to health care services for our nation's veterans and TRICARE beneficiaries. For example, in Boise, as I mentioned, we had difficulty signing up the full complement of providers given what appears to be an insufficiency of federal reimbursement rates compared to those in the civilian market. A number of these specialties are now available with the signing of providers in the Boise VA Medical Center, to include general surgery, gastroenterology, internal medicine, geriatrics, radiology, anesthesiology, and infectious disease.

Second, in several communities throughout our Region, the Departments of Defense and Veterans Affairs' providers occupy adjoining space, if not the same physical space. This has led to a successful sharing of talents and resources, which has benefited both health care systems and beneficiary populations tremendously.

And, third, this relationship is good for the taxpayer as it maximizes the federal investment in plant, equipment and personnel.

We are pleased with the relationship that we have begun to develop with the Boise VA Medical Center. They are a critical part of our network and we and the TRICARE beneficiaries in this community value the services that they provide.

We hope that this relationship continues to foster and grow over the coming years, as a strong relationship between ourselves, the Boise VA Medical Center and the military treatment facility at Mountain Home Air Force Base will only serve to maximize the value to the beneficiaries and the taxpayer.

You know, Mr. Chairman, to many the thought of the two largest health care systems in the world – those run by the Departments of Defense and Veterans Affairs – working together to meet the health care needs of the most deserving population we know is incomprehensible; not due to mission or necessarily desire, but complexity and culture. The fact is, these are two different systems... that are complex, with different cultures and sometimes different missions. But, from what I have seen close up, I believe there is a commitment by both Departments to work together to meet the needs of this deserving population.

In closing, I would just like to say that TriWest and our Idaho-based owner, Regence BlueShield of Idaho, consider it a privilege to assist the Department of Defense and more specifically, the military treatment facility at Mountain Home Air Force Base, in meeting the health care needs of the TRICARE beneficiaries in the Central Region.

In addition, Mr. Chairman, I would be remiss if I didn't express our support for the work that you are doing to bring Medicare Subvention to our nation's veterans and military retirees and their families. I believe that the demonstrations are a good start in helping to sort out the right approach to addressing what in many people's eyes has been a breach of contract with those who have stood in harm's way in defense of our country in its times of need. And, quite frankly, the issue would not be where it is today were it not for your tireless leadership.

Mr. Chairman, I look forward to addressing any questions or comments that you or the other members of the Subcommittee might have for me.

David J. McIntyre, Jr.
President and Chief Executive Officer

Mr. McIntyre, President and CEO of TriWest Healthcare Alliance, is ultimately responsible for the successful operation of TriWest and the administration of the TRICARE Central Region contract. Mr. McIntyre was the architect of the strategic vision on which the TriWest proposal submission was based. In addition, he was responsible for pulling together the shareholders and vendor subcontractors of TriWest, and managing the development of the proposal.

Mr. McIntyre has more than 12 years of experience, success and accomplishments in national health care policy development. He served for nearly nine years in offices of the United States Senate, where he was responsible for health policy issues, most recently as a senior aide to Senator John McCain (R-AZ). In this capacity, Mr. McIntyre authored a number of proposals that became part of the TRICARE program. As a Vice President of Blue Cross and Blue Shield of Arizona, Arizona's largest health care organization, Mr. McIntyre managed numerous strategic projects including the development of TriWest and its government proposal, assisted with the management of the corporation's strategic planning process, and had direct responsibility for legislative matters, media relations and product development projects.

Mr. McIntyre has a master's degree in administrative sciences (with an emphasis in management and health policy/administration) from Johns Hopkins University. Additionally, he completed the Executive Education Program for Senior Government Managers at Harvard University.

Mr. McIntyre frequently addresses Arizona and national groups on health policy matters. He is past-President of the Arizona Association of Managed Care Plans (representing Arizona's managed care industry) and serves on the board of several Arizona health care entities.

STATEMENT OF
GARY BERMEOSOLO, ADMINISTRATOR
IDAHO DIVISION OF VETERANS SERVICES
BEFORE THE
SUBCOMMITTEE ON HEALTH
OF THE
COMMITTEE ON VETERANS' AFFAIRS
HOUSE OF REPRESENTATIVES
JUNE 30, 1998

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Mr. Chairman and Members of the Committee:

My name is Gary Bermeosolo, and it is my pleasure to serve the State of Idaho as its Administrator of Veterans Services. I want to thank you for coming to Idaho and for your sincere concern for the health-care needs of the veterans of our great state.

In today's greying America, there is an invigorated interest in looking for innovative ways to care for our aging veteran population. The first State Veterans Home, established in Rocky Hill, Connecticut 134 years ago, was indeed an innovative way of caring for those who had "borne the battle." Other states followed Connecticut's lead and on August 7, 1888, a grateful federal government enacted what was perhaps the first federal grant-in-aid program by providing an annual payment of $100 per year to states with Veterans Homes. In 1895, a group of concerned citizens made Idaho one of the first western states to pioneer the concept of "Caring for America's Heroes" in a state-operated Veterans Home.

Over the years, our state has maintained a close working relationship with the Boise Veterans Affairs Medical Center (VAMC). In 1966, that relationship led to the relocation of the Boise Home from its original site on the outskirts of town to a corner of the VAMC grounds, where it remains today.

The Home's close proximity to the Boise VAMC has enabled us to jointly pursue innovative approaches to improving health care. In 1982, the Home entered into a unique "agreement" with the Boise VAMC that allowed us to share resources and, consequently, improve the standard of care for our long-term-care residents. This demonstration project was so successful that changes were enacted to Title 38 U.S.C. allowing other State Homes to enter into similar sharing agreements.

Today, the citizens of Idaho enjoy three State Veterans Homes with homes in Pocatello, Lewiston, and Boise. Our State Home Program is a shining example of what Past President Ronald Reagan termed "New Federalism." The program demonstrates what can be accomplished when both federal and state government are committed to a common cause.

Mr. Chairman, while we are proud of our achievements, there are steps that should be taken to strengthen and enhance our State Veterans Home Program. Today, with your indulgence, I will advance four suggestions for your consideration:

1. VA per diem payments to State Homes should be increased: Of the options available to VA for the placement of veterans needing skilled nursing care, the State Veterans Home Program is by far the least expensive. In fact, VA is aware they should be doing more to offset their fair share of our costs. Consequently, last year we received written assurances from VA that it intends to increase its level of per diem support to an amount equivalent to 1/3 of the national average cost of providing care in a State Veterans Home.

We agree with VA's per diem assistance goal and ask that your committee ensure that VA provides the maximum annual increase allowed under Title 38 U.S.C. until its 1/3 goal is attained.

2. Congress should meet its commitment to fund 65% of the construction costs of State Veterans Homes: Mr. Chairman, last year your committee supported an

$80 million appropriation for the State Veterans Home Construction Grant Program. We thank you for that support and ask that, this year, you support the Senate Appropriations Subcommittee recommendation of $90 million. The Senate Subcommittee recommended this amount after noting there is a backlog of $150 million in Priority One projects from fiscal year 1998. We agree with their observation that "this program is a cost-effective means of meeting the long-term health care needs of veterans."

3. The methodology for awarding State Home construction grants needs to be updated: Idaho is one of many states that have a State Home Construction Grant project pending, but cannot forecast when federal matching funds will be available to begin construction. We are currently #53 on VA's construction priority list. We have remained at #53 for three consecutive years despite the $175 million Congress made available to the program during that three-year period.

The reason for our failure to advance on the priority list is that under the current system, "new home" construction projects move to the top of the list which forces renovation projects, such as ours, down the list and out of funding range. State directors, such as myself, are then faced with the arduous task of convincing our state elected officials to leave state matching funds intact, in some cases for years, as we wait for federal matching funds to become available.

Mr. Chairman, in the interest of equity, we ask that your committee pursue changes to the way grants are prioritized and awarded in the State Home Construction Grant Program. Idaho endorses the approach forwarded by the National Association of State Veterans Homes:

> Requests should be prioritized, in the year they are received, utilizing current VA needs criteria. Grant requests received in future years should be prioritized in the same manner with the understanding that they will not receive funding until projects submitted in previous years are funded. However, a state without a State Veterans Home (there are only three that do not have an application in process . . . Alaska, Hawaii, and Delaware) should automatically become eligible for funding for its first Home regardless of the year its request is received.

4. State Veterans Homes should play an integral part in VA's plans to expand personal-care services to veterans: Today, a major health-care trend is the provision of "personal-care services." The inclination is to move away from traditional institutionalized care in favor of providing an array of health-care services designed to enable those who wish to remain in their own homes to do so.

VA has implemented a number of hospital-based and contracted personal-care service programs designed to assist aging and disabled veterans in continuing to live at home. It stands to reason that the network of 95 State Veterans Homes in 44 states across our country provides an avenue of opportunity for VA to further develop this concept at reduced costs.

Congress should enact legislation that would require VA to establish a State Veterans Home Based Personal-Care Services Program, utilizing a funding formula similar to the one currently utilized in the State Veterans Home Per Diem Program. VA should offset 1/3 of the projected national average cost of providing such care.

The prospect for the success of such a program is exciting. State Veterans Homes, such as ours in Idaho, could make an immediate impact on reducing the number of veterans being forced to move out of their homes and into health-care institutions; one move most of us would prefer not to make.

Mr. Chairman, by the end of this decade, there will be more than 100 State Veterans Homes in 47 States. The opportunity for "partnering" with VA, as we have done in Idaho in the past, remains a viable and cost-effective solution to many of the health-care challenges confronting us today. We must remain committed to sharing the responsibility for meeting the challenge of "Caring for America's Heroes." Without the integration of all available resources, we will fail to meet our moral obligation; and the veteran and other taxpaying citizens will be the ultimate losers.

Thank you, Mr. Chairman.

Prepared statement of Alan G. Lance, Attorney General, State of Idaho

Mister Chairman and Members of the Committee,

My remarks this morning will be divided into two sections. I will speak first as Attorney General of the State of Idaho regarding a lawsuit my office was forced to bring as a result of the Clinton Administration's illegal attempts to withhold certain veterans benefits to Idaho veterans. I will also speak on behalf of the American Legion - Department of Idaho, and as consultant to the American Legion's National Legislative Commission.

First, as Attorney General of the State of Idaho, let me welcome you to the State of Idaho, our capital city and our magnificent statehouse.

We are encouraged that you have traveled this distance to examine the quality of health care available to the 110,000 Idahoans who are war-time veterans. Veterans in Idaho have access to VA health care through the Veterans Integrated Service Network (VISN), 20 facilities that include VAMCs in Boise, Idaho, Spokane and Walla Walla, Washington, and the Boise Vet Center. Aspects of tertiary care are referred to VAMC in Seattle, Washington and, in some cases, Salt Lake City, Utah. In the southeast part of our state, veterans can access primary care services via the Community Based Outpatient Clinic (CBOC) and Vet Center in Pocatello that is managed by VISN 19 through the parent facility in Salt Lake City.

In addition to the federal health care facilities, the State of Idaho operates three veterans homes, located in Boise, Lewiston and Pocatello.

I understand that earlier today you had the opportunity to visit the Boise VAMC and I hope you will also have the time to tour the State of Idaho Veterans Home in Boise.

I also invite you to visit the Office of the Attorney General. I would welcome the opportunity to show you some of Idaho's interesting history. The Office is located on the second floor, immediately behind the gold leaf equestrian statue of one of our most respected veterans, a fellow by the name of George Washington. By the way, the statue was presented to the Territory of Idaho in 1869.

I am very concerned with the apparent lack of dedication on the part of the Clinton administration to those who have defended our freedom. And I ask your support in reminding Washington, D.C. of the deal struck between the American people and their government. It is a simple deal: You risk your life for your country and, if you survive, your country will provide certain benefits.

Among those benefits are residential care and prescription medications for certain eligible veterans. Regrettably, the current administration attempted to disregard those commitments at the expense of both veterans and state taxpayers.

In April,1997 the Spokane VAMC notified the Idaho State Veterans Home - Lewiston that the VAMC would no longer fill prescriptions for residents of the veterans home.

Following correspondence with my office, the VAMC reversed itself. In July, 1997, the Spokane VAMC said it would furnish medications requested by veterans, but would not pay the federal per diem share of those veterans' nursing home costs.

In September, 1997 the Salt Lake City VAMC advised the State Veterans Home in Pocatello that Salt Lake would institute the same misguided policy in Pocatello on October 1.

As you are well aware, the benefits in question are not some kind of welfare handout, but, rather, an entitlement, earned by veterans who risked their lives for their country.

The prescription benefit is codified at 38 U.S.C. Section 1712 subsection(d) and has been required by law for more than 30 years.

38 U.S. C. Section 1741 requires the VA to make per diem payments of $39.64 per veteran per day to states for veterans home care. The payments offset the State of Idaho's cost of approximately $110 per day.

These policy maneuvers by the VA, not authorized by Congress, were an insult to veterans and a national disgrace. The effect of the administration's policy change was to shift the cost of entitled veteran health care to the taxpayers of Idaho and to the veterans themselves.

As a result of these actions, my office filed a lawsuit in Federal District Court. The VA's response was to stall, by attempting to avoid answering the complaint. The VA said it needed time to study the issue. The issue being: whether the VA should comply with the law.

That position was unacceptable to the State of Idaho and my office obtained a court order in November of 1997, requiring the VA to respond by December. In the interim, the Salt Lake VAMC notified the State Veterans Home in Pocatello that, in light of the lawsuit, Salt Lake VAMC would not implement its announced policy change.

Finally, in December of 1997, the VA backed off and agreed to comply with federal law. The VA announced a new national policy in a memorandum by Under-Secretary of Health for the Department of Veterans Affairs, Kenneth W. Kizer.

The memorandum states, "VHA facilities may no longer withhold per diem payments from states because eligible veterans in their state homes receive prescription drugs from VA." I applaud Under-Secretary Kizer for making the right decision.

The lawsuit was brought to resolution by a January 20, 1998 settlement agreement. The VA agreed to comply with federal law by providing prescription medications to eligible veterans and paying per diem to the State of Idaho. The VA further agreed to reimburse the Idaho Veterans Home - Lewiston $26,863.03 for financial losses resulting from the VA's unlawful action.

I am gratified that our efforts on behalf of Idaho veterans are paying dividends for all veterans nationwide. I am exasperated, however, that a lawsuit was necessary in order to force the administration to keep the country's promise to veterans. And I remain unconvinced that the administration is any more committed to these veterans benefits today than it was in April of 1997. For that reason, we stipulated that our lawsuit be dismissed without prejudice, thus reserving the state's right to return to court should the administration attempt to renege on this deal.

Mr. Chairman, the balance of my remarks are presented on behalf of the American Legion - Department of Idaho.

Based on feedback from veterans here in Boise, as well as National VA Patient Satisfaction Data, the American Legion - Department of Idaho believes veterans are generally satisfied with the care provided by the Veterans Health Administration (VHA). Yet there are still many challenges associated with the delivery of care in a largely rural Service Area that remain ahead for VAMC Boise and, indeed, all of VISNs 19 and 20 that cover Idaho.

For instance, access is often a key issue, especially for veterans who do not live in the immediate Boise area. According to VA figures, VAMC Boise services approximately 20% of the eligible veterans in this county. But by the time one gets 100 miles southeast to Twin Falls, this number drops by one-half. The nearest VA medical center may be hundreds of miles away for some veterans. A veteran living in Salmon, Idaho is 246 miles from VAMC Boise, 340 miles from VAMC Spokane and 373 miles from VAMC Salt Lake City.

While VA is beginning to establish a better community presence with community based clinics, veterans still must seek initial appointments at the VAMCs and only scheduled appointments are available at the clinics. Specifically, Pocatello veterans must travel to Salt Lake City, about a 3.5 hour drive, for initial treatment before they can be seen at the Pocatello Community Based Outpatient Clinic, and they must return to Salt Lake City for any type of treatment beyond primary care. There is a three month waiting list for an appointment at the Pocatello clinic. With the initiative to further bring basic services closer to veterans via the CBOC in Twin Falls in September of this year, veterans will have to first seek care at VAMC Boise, 133 miles from Twin Falls, before they can be referred to the CBOC. While these facilities only treat veterans who are part of the existing workload, processing at these sites needs to be explored to facilitate veterans access.

Emergency care is also an issue for veterans living in outlying areas. Emergency personnel responding to a request for assistance take patients to the nearest hospital. For veterans, this often means they incur the cost of this care. The regulations governing authorization of payment of non-VA care are stringent. When veterans are treated at private sector hospitals because of proximity, they are often put in conflict with the regulations and must assume the burden of payment. VA is looking at the issue of emergency services, especially in light of the discussion of consumer rights in the report of the Advisory Commission on Consumer Protection and Quality in the Health Care Industry. It is an issue that quite possibly warrants focused oversight.

The availability of provider coverage is also an issue in some areas. It is our understanding that TriWest, the TriCare intermediary in this region, has encountered difficulties in finding providers in some rural areas, including Idaho. VAMC Boise provides services as a TriCare subcontractor. However, their efforts to explore expansion of services with TriCare can not move forward without accurate utilization data from TriWest.

VAMC Boise has been operating within an essentially straight line budget over the past several years. The FY 98 budget is $54.3 million, including Medical Care Cost Funds. The station has been conducting outreach to increase the number of veterans treated. The fairly stable number of 11,000+ unique veterans treated over the past several years is projected to increase 10% in FY 98 to 12,300 veterans. This is expected to include a 7% increase in Category A veterans and a 3% increase in Category C veterans. However, there remains a large degree of uncertainty about which priority groups VA will be able to treat, within existing resources, under the new enrollment process.

VAMC Boise has sharing agreements with Mt. Home Air Force Base, the Indian Health Service, U.S. Forest Service, State of Idaho, Idaho State Veterans Home, and community health facilities as well as the 92nd Medical Group at Fairchild Air Force Base. VA has set the goal of generating 10% of its revenue from non-appropriated sources. This station's fiscal year 98 goal of $3.9 million will be difficult to reach. VA's reliance on medical care cost funds and its ability to collect these funds merit continued monitoring.

During a period of tremendous change involving rightsizing, re-engineering and a tough fiscal climate, VAMC Boise has done well in responding to veterans' needs. On VA's most recent National Patient Satisfaction of Ambulatory Care, VISN 20- was cited as a center of excellence with scores significantly above average. VAMC Boise leads the VISN. The station appears to have good mechanisms in place to evaluate both veteran satisfaction and the VAMC's activity in various performance domains. This is essential in maintaining an effective delivery system.

The American Legion appreciates the Boise VAMC's efforts to provide quality, accessible medical care and service to the veterans of this region. However, we remain concerned that the drive toward cost-containment and straight-line budgets may again tempt management to seek ways around VA statutory obligations to this nation's veterans. This was clearly evident in the actions which led to the lawsuit I discussed previously.

Finally, Mr. Chairman, The American Legion believes it is important to have a clear vision of VHA beyond the current strategic planning period. Many of the changes occurring within VHA over the past few years are the result of a need to transform a system that was essentially unchanged since its inception. The American Legion applauds these changes, but also believes there is more to be accomplished. Therefore, The American Legion has devised a plan to transform and improve the VA health care system based on its analysis of the major problems within VHA. That plan, as just recently presented before this subcommittee, is contained in the GI Bill of Health.

We believe the GI Bill of Health is a vision for excellence in veterans health care. It provides:

- an opportunity for all veterans and their dependants to access VA services.
- an opportunity for alternative revenue streams that will lessen the system's dependence upon congressionally appropriated funds.
- an opportunity to increase the access points of VA medical care.
- a mechanism to strengthen all of VA's specialized services by offering them to veterans who currently may not be able to access these programs.

This plan is directly applicable to the needs of veterans living in rural areas because of its component that strives to increase the access points of VA medical care. The GI Bill of Health would provide greater leverage in negotiating contracts with private health care providers, thus promoting an expanded VA network with partnerships in the federal and private sector. This coordinated approach would help to address the current rural health care problem, since the VA would be capable of moving access to health care physically closer to veterans' residences through its options to provide VA or contract services. This could help strengthen rural health care clinics and hospitals.

The American Legion believes it is possible for all veterans to have equal access to VA medical care based on the following principle: If a veteran qualifies for care, under title 38, United States Code, access to the VA medical care system would be at no cost to the veteran. Otherwise, the veteran would be responsible for reimbursing VA for the medical care received, either directly or through third-party health insurance. Using this formula, VA medical

care funding would essentially come from two sources; the United States Treasury and the private health insurance sector. Using this same philosophy, the GI Bill of Health presents an opportunity for VA to expand access to health care for the veteran's dependents.

The GI Bill of Health is designed as a creative and visionary, yet workable and fiscally responsible, solution to provide VA health care to all veterans.

In closing, Mr. Chairman, let me repeat that we are encouraged to have you and the committee visit our state. I subscribe to the Orrin Hatch theory that "a deal is a deal." The circumstances necessitating the State of Idaho's lawsuit suggest that the Clinton administration finds that concept outdated. As a result, veterans in the State of Idaho and throughout the nation must depend on you who serve in the Congress. I ask for your continued vigilance and commitment to stand behind the promises our country made to our veterans. Your presence in Idaho today is evidence of your vigilance and underscores your commitment.

I would be happy to respond to any reasonable questions.

STATEMENT OF
SHIRLEY M. SCOFIELD
STATE COMMANDER
OF THE
DISABLED AMERICAN VETERANS
DEPARTMENT OF IDAHO
BEFORE THE
HOUSE OF REPRESENTATIVES
COMMITTEE ON VETERANS' AFFAIRS
SUBCOMMITTEE ON HEALTH
BOISE, IDAHO
JUNE 30, 1998

MR. CHAIRMAN AND MEMBERS OF THE VETERANS' AFFAIRS SUBCOMMITTEE ON HEALTH:

On behalf of the more than six thousand members of the Disabled American Veterans (DAV) and our Auxiliary and the eighteen chapters and thirteen auxiliary units throughout Idaho, it is indeed an honor and a privilege to appear before you today to discuss the health care issues of this state's service-connected disabled veterans, their families and survivors.

At the outset, I wish to thank you and your Subcommittee for holding this field hearing and for the support you have given to Idaho veterans, their families, and to the veterans' programs that have enhanced their lives during the 105th Congress. As advocates for our Nation's veteran population within Congress, you are called upon to provide the critical leadership necessary to ensure that America honors its moral obligation to the men and women who served in our Armed Forces and fought to preserve the freedoms enjoyed by the citizens of this Nation and countless others throughout the world.

The DAV believes that in order to achieve a cost-efficient health care delivery system, Department of Defense (DOD) and Department of Veterans Affairs (VA) must provide independently, but whenever possible, in concert, high quality care in a dependable and consistent manner with minimal variation over time or distance.

With the downsizing of DOD and VA facilities, new cooperative agreements should be reached to enable the two health care systems to function more effectively and efficiently to serve the needs of the members of our Armed Forces, their dependents and survivors.

In order to provide greater access to VA health care, medical care savings are being reinvested in patient care by increasing access opportunities through the creation of additional Community Based Outpatient Clinics (CBOCs), telemedicine, mobile clinics, partnering with Vet Centers, and the piloting of Veterans Health Resource Centers.

The DAV has consistently called for and supported a comprehensive VA health care system for entitled veterans. It is our belief that the system should:

- Provide entitlement to guaranteed access to a full continuum of care from preventive through hospice
- Preserve the VA's mission and role as a provider of special services in areas such as blindness, amputation, aging, mental health, and long-term care
- Maintain an adequate work force of highly skilled and trained health care providers who are adequately compensated
- Provide a strong and veteran-focused research program.

The DAV has further called for enactment of legislation that would promote a broader and greater degree of sharing between the health care systems of the VA and DOD. By the sharing, but not merging, of facilities, staff and expertise, it is our opinion that health care delivery for current and former members of the U.S. Armed Services will be better served, as will our Nation.

Assuming no significant military engagements (a possibly thin assumption when we read of the hostilities throughout the world), the veteran population is expected to decline by five million over the next ten years.

However, while the overall numbers of veterans are expected to decline, the characteristics of the veteran population served by VA will result in a higher demand for healthcare services. In particular, this is because the veteran population is aging, and in need of more costly medical care. Also, there are more female veterans in need of services from the VA.

Current VA patients, when compared to private health care patients, are not only older but they also are generally more likely to be disabled.

The fiscal year (FY) 1999 budget for the VA is only 0.2% more than the FY 1998 budget. This actually represents a reduction in funding because it does not even cover increased costs due to inflation. Because of years of inadequate funding,

some veterans' programs are already in shambles. VA staffing is so inadequate and the claims' backlogs are so large, it often takes veterans years to get proper decisions on their disability compensation and pension claims. Many veterans die waiting. Similarly, veterans often must wait months for clinic appointments for serious medical conditions.

The DAV, and I am sure almost everyone in the veterans' community, was extremely disappointed by President Clinton's budget request. Not only does the 0.2% increase in VA funding fail to provide adequate resources to improve the quality and timeliness of the VA benefits delivery system and to ensure adequate, quality health care to our Nation's sick and disabled veterans, the Administration's proposed legislative and administrative changes indicate a fundamental shift in national policies toward veterans.

The budget request also provides less funding for VA health care than this year. By our calculations, the VA health care appropriation is more than $1 billion below current service levels. This level of funding is inadequate to care for our Nation's sick and disabled veterans, particularly in light of the sacrifices they have made in the name of duty, honor, and country.

These brave men and women are forced to watch as new Government initiatives are funded or other Government programs are provided increased funding, while the programs they rely on are being strangled. For example, the transportation funding level was increased by 43%!

The morale of VA health care providers is at an all time low here in Idaho and throughout the country. The patient work load continues to rise, while VA health care staff are still being cut which leads to an unsafe healthcare environment.

Outpatient clinics, (that is) primary care, optometry, gastro intestinal orthopedics, audiology, neurology, etc. are "booked out" for months and with some until the end of the year. These delays in treatment are creating health hazards as well as negative health care outcomes and unnecessary deaths.

In addition to patient care delays, physicians and other health care providers are being forced to work ten to twelve hour days. And the nursing-patient ratio within the inpatient and nursing home care units is so compromised that patient safety is being compromised.

On March 31, 1998, the U.S. Senate Republican Policy Committee chaired by Idaho's Senior Senator Larry Craig, distributed "talking points" regarding the

payment of disability compensation to veterans for tobacco-related conditions. These "talking points" contain serious errors and gross inaccuracies, which totally misrepresented the issue before and during the floor debate on the Senate Budget Resolution on April 2, 1998.

The "talking points" inaccuracies were used to support the amendment introduced by Senator Pete Domenici (R-NM) which allowed the Senate to rob $10.5 billion from VA disability compensation and give it to the already bloated transportation program (H.R. 2400).

The following explanation will set the record straight on this very important issue:

- The provision of disability compensation for tobacco-related illnesses were inaccurately characterized as a new and expanded benefit. In fact, the VA Office of General Counsel, both in this Administration and the previous Administration, has merely determined that existing law provides for such compensation.

- The "talking points" note that the President has requested legislation to repeal the provision of tobacco-related disability compensation without noting the stated rationale for such legislation is the mistaken belief that such compensation is too costly for the government—not that it was inappropriate.

- The "talking points" state that smoking is solely a matter of personal choice when medical science has determined that it is a chemical dependency. Additionally, for more than a century tobacco use was encouraged and promoted by the military. Further, the entire premise of the tobacco settlement was that tobacco companies are responsible for knowingly withholding the risks and probable consequences of tobacco use from the public.

- The claim that tobacco use falls within the definition of abuse of alcohol, drugs or is willful misconduct is reprehensible and the height of hypocrisy, given the fact that the military environment fostered and encouraged tobacco use.

- The "talking points" claim that "no veteran– current or future– will be denied medical care" when, in fact, access to VA health care is governed

by strict criteria providing guaranteed access to veterans only for service-related illnesses or disabilities.

- The claim that any veteran can be compensated at any time after service for any condition related to tobacco ignores the fact that, to date, VA has approved less than 300 such claims and has strict standards for the granting of claims.

- The "talking points" state that all veterans—current and future—can still receive Social Security benefits for tobacco-related disability. Not all veterans are eligible, for Social Security Disability Insurance and even if eligible must meet the definition of permanent, total disability to receive benefits.

- The claim is made that allowing veterans to pursue disability compensation for tobacco-related conditions will over burden the VA's claims processing system. To date, only 8,300 claims for tobacco-related illnesses have been filed since 1993, not the 500,000 purported in the "talking points."

The "talking points" do contain, however, one statement that bears the mark of accuracy "Stopping this...allows Congress to fund much-needed transportation construction." This is the sole issue: The 105th Congress denied benefits to disabled veterans to further add to an already obscene spending binge on transportation and highways.

In light of these shortfalls, on April 2, 1998, a slim majority in the Senate robbed more than $15.5 billion over five years from disabled veterans and gave it to the transportation program, projected to increase by 43%. This action was taken not on the merits of the issue but solely on the basis of pork-barrel politics in this election year.

The House continued to perpetuate this reprehensible attack on disabled veterans when on May 22, 1998, the amendment to the conference report on HR 2400, submitted by Representative David Obey of Wisconsin, was defeated 190 to 195. The members of the Department of Idaho are pleased that both of our Representatives, Michael Crapo and Helen Chenoweth, as well as Congressman Clifford Stearns voted for veterans to recommit the conference report.

Veterans across the Nation are closely watching this year's budget process, and counting on your leadership to protect veterans' disability compensation. Please do not let us down.

I also request that you reject the misguided and unwarranted efforts to preclude the payment of disability compensation for tobacco-related illnesses, and support efforts to restore the benefit. I also request that you reject the misrepresentations, myths and hyperbole that have been used to obscure this issue, to promote another specious study, and rob disabled veterans.

I pledge the DAV's continued support for your efforts to ensure that America's service-connected disabled veterans, their families and survivors are adequately cared for. I also want you to know that the DAV continues to take our message to other members of Congress. During the past year, the DAV and other veterans service organizations took to the airways, via telephone, the printed media, and the halls of Congress. That message was simple—the VA must have adequate funding to serve the needs of veterans and their families.

Because of the disastrous budget proposed by the Administration for FY 1999, we have continued these efforts. The FY 1999 budget request is built on the backs of veterans. It is worse than smoke and mirrors because it is premised on the total illusion that our Government will "save" $17 billion over five years if veterans' compensation is eliminated for tobacco-related disabilities. This figure is unrealistically inflated so as to be meaningless.

I used to believe that veterans could rest on their past accomplishments, and that a grateful Nation would be willing to take care of the needs of its defenders of democracy. But time has proven me wrong. Veterans can no longer be assured that this Government will fulfill its past promises to them.

Our detractors, and there are many, in Congress, in the Administration, and in the media, would have the American public believe that veterans' programs are too generous; that veterans and veterans service organizations only want more, more, more; that we are unwilling to listen to reasonable alternatives; and that VA health care is provided only to the social misfits. These impressions could not be further from the truth, yet they keep surfacing, year after year, and most recently, in the Administration's budget proposal.

As members of the Veterans' Affairs Committee, you are acutely aware that over the last two decades, veterans' programs and services have been cut by more than $12 billion. Also, during a time when expenditures for other Federal programs

were increasing at an extraordinary pace, the cost of veterans' benefits was held to a virtual straight line.

Veterans' programs are not the cause of this country's fiscal problems; while we recognize that the members of the Veterans' Affairs Committee understand that caring for America's veterans is a legitimate, continuing cost of war, we call upon you to help us educate your colleagues in recognizing that we, as a Nation, owe a great debt to our Nation's veterans. Most importantly, your colleagues must recognize the debt is due now. Veterans must be our Nation's first priority. Our Government must fulfill its promises to our Nation's veterans before making new commitments. How many times must we state this simple fact before all members of Congress and the Administration heed our words?

On January 27, 1998, President Clinton addressed this Nation and challenged us all to use this time as an opportunity to prepare for the next century. The theme of the Administration's millennium program is "Honor the Past; Imagine the Future." The President invited all Americans to "give gifts to the future" to enhance future generations.

Sadly, veterans were not mentioned once in the State of the Union, nor in the Republican's response to the State of the Union—not once. How can we as a Nation honor the past without remembering the sacrifices made by our Nation's citizen-soldiers? Remembering veterans twice a year—Memorial Day and Veterans Day—is not sufficient. It is difficult to imagine the future without reflecting on the sacrifices made by veterans in past wars, by today's veterans serving in harm's way in the Persian Gulf and Bosnia and, most likely, by future veterans who will serve our Nation on foreign soil in its quest for world peace.

All of the veterans in this room today have already given a gift to the future—a gift of freedom and unprecedented personal rights and liberties enjoyed by all Americans and many others around the world. This gift did not come without a price; for some it was the ultimate sacrifice of life, for others it was the loss of limbs, eyesight, or mental or physical well-being.

This gift of giving—or sacrifice—has not ended. As I will discuss later, these same men and women who have given so much continue to freely give to their less fortunate comrades.

We believe that VHA is headed along the right path, but adequate resources are still required in order for VHA to provide needed care to our Nation's sick and disabled veterans.

Before I move on, I would again like to emphasize that the contributions and sacrifices of disabled veterans put them in a totally different category from someone receiving social welfare support. America can never fully repay these veterans for the anguish, personal sacrifice, and hardships they have endured through the injuries received during their military service. The DAV believes that veterans' programs should always be viewed as the most important of national obligations and among the highest priorities for Government funding.

The DAV is also deeply concerned about the problems facing our Persian Gulf War veterans, especially those who still suffer from ailments referred to as "Gulf War Illnesses." We are encouraged by pending legislation that would provide oversight into Government research projects and the VA's ability to pay disability compensation to Persian Gulf veterans suffering from diagnosed ailments determined to be associated with their service in the Persian Gulf theater.

I am pleased to say that the DAV continues to hire Persian Gulf War veterans as part of our National Service Officer Training Program. To date, we have hired more than 150 Persian Gulf War veterans who have gone through, or are currently going through, our training academy in Denver, Colorado.

Earlier this month, our National Commander, Harry R. McDonald, Jr. of Florida, wrote a letter to every member of the VA/HUD and Independent Agencies appropriations committee requesting a moratorium on implementing the VA's National Formulary of Medications, supplies and health care products. The request was made following hundreds of complaints generated by our members as well as from VA health care providers. The comments dealt with delays in physicians' abilities to go off formulary due to the clinical needs of the patient, inferior products, as well as the inability of the formulary to keep pace with new products which will improve the patient's preventive and acute needs rather than waiting until the patient is in a chronic and life threatening health care state.

Let me just briefly mention one other area that should be receiving attention from your Committee. These issues include expanding presumptions for service connection for POWs; requiring the Government to keep its promises to military retirees, such as providing free medical care to military retirees and their dependents.

Despite what some would have you believe, veterans are not asking for more, more, more. Please do not misconstrue our opposition to the elimination of compensation payments and the diminishment of VA's ability to process benefit

claims and provide quality health care as an unwillingness on the part of disabled veterans to help our Nation overcome its financial woes and maintain a balanced budget.

Actually, just the opposite is true when you realize that thousands of veterans across the country give so freely of their time and money so that VA may continue to provide some semblance of service to America's sick and disabled veterans.

During the twelve month period from January 1, 1997, to January 1, 1998, more than 10,700 DAV and Auxiliary volunteers across the country donated 2.4 million hours of volunteer service to the VA with the DAV here in Idaho; credited with over 8,400 of those hours. These volunteers performed essential services to hospitalized veterans which saved our Federal Government more than $31.4 million in employee costs.

The DAV also employs 196 Hospital Service Coordinators (HSCs) at VA facilities around the country. The DAV's National Transportation Network logged in more than 18 million miles and transported more than 500,000 veterans to VA health care facilities during 1997 alone. More than 5,000 volunteer drivers spent 1.2 million hours transporting veterans during 1997. Since our National Transportation Program began in 1987, more than 3.6 million veterans were transported more than 148 million miles.

The DAV Department of Idaho and our Chapters, together with the National Organization, have donated more than 700 vans to VA medical centers across the country at a cost of nearly $11 million. This year, an additional 147 vans were donated to the VA, at a cost of more than $3.2 million, the largest donation to date.

On June 17, 1998, on the West Front Lawn of the Capitol, the DAV donated two additional vans for veterans health care transportation for use at Baker City, Oregon and here in Burley, Idaho. Idaho now has eight vans for the transporting veterans from five states for health care via the VA.

It was our belief that it was extremely important that members of Congress understand the savings that have been provided to our Government because of the DAV's transportation network.

The DAV was founded in 1920 and chartered by Congress in 1932 as a primary advocate for America's service-connected disabled veterans, their dependents and survivors. Since 1920, the DAV has been dedicated to one single purpose: building better lives for disabled veterans and their families. In fulfilling

our mandate of service to America's service-connected disabled veterans and their families, the DAV employs a corps of 270 National Service Officers (NSOs), located throughout the country. Last year, these men and women, all wartime service-connected disabled veterans, represented some 240,000 veterans and their families in their claims for VA benefits, obtaining for them more than $1.8 billion in new and retroactive benefits.

We are extremely proud of the services we provide to our Nation to assist it in fulfilling its mission to sick and disabled veterans. As the above statistics so dramatically demonstrate, we know first-hand of the sacrifices made by veterans and the problems they face due to their disabilities. The DAV is willing to continue to pitch in and give more than our fair share. It is now time for our Government to do its fair share—making veterans' programs one of the most important obligations and one of the priorities for Federal funding. Anything less is a breach of this Government's commitment to its veterans.

This morning I have attempted to outline to the Committee the DAV's observations regarding the state of veterans' affairs in Idaho. I have noted some criticism of the way veterans have been treated over the past dozen years and ask that veterans' programs be given the priority that has been earned by the recipients of those programs.

I have expressed willingness on the part of the Idaho members of the DAV and Auxiliary to give of their time and resources so that other sick and disabled veterans may receive some degree of service at VA health care facilities. I have also explained the service provided to veterans and their families by DAV NSOs, HSCs, our National staff's in Washington, DC and Cincinnati, Ohio as well as our volunteers. However, I must tell you, in all candor, that America's veterans can no longer tolerate being pushed around by the political power brokers. No longer can our Nation's veterans tolerate elected officials who would rather blindly cut every Federal program—regardless of the program's value or contribution to the National debt—than make the difficult political choices necessary to fulfill this Nation's commitments to its citizen-soldiers. We will not idly standby while our programs are cannibalized to fund other programs.

Mr. Chairman, this ends my prepared presentation. I will be happy to answer any questions you and the members of your Committee may have.

Thank you and may God Bless America and those who have served this great Nation.

STATEMENT OF T.C. BROCK, SENIOR VICE COMMANDER, VETERANS OF FOREIGN WARS OF THE UNITED STATES

It is the position of the Veterans of Foreign Wars that we must seize the initiative in ensuring that we as a nation fully acknowledge and reward the service and sacrifices of our military veterans. And in no other area is thc importance and challenge of meeting this obligation more apparent, more compelling than with respect to health care. We are, therefore, most gratified to take part in today's important hearing addressing the future of the VA Health Care System.

We contend that veterans should have the same unhindered access to state of the art health care as is enjoyed by this country's economic, political and social elite. Nothing less is acceptable. Of course, meeting the needs of our service-connected disabled veterans must be our first priority. But the VFW maintains that all individuals who have committed to placing their very lives on the line in the service of our national defense as members of the armed forces are owed nothing less than the best this nation has to offer with respect to meeting their health care needs.

It is our view that the single greatest obstacle in the path of achieving this goal is the damage wrought to the veterans health care system by decades of inadequate funding. We deem it unconscionable that the President's budget submission for VA falls woefully short with respect to providing for today's need while allowing the system to prepare for future demand.

That it would provide only $17.028 billion in appropriations support for VA Medical Care in FY 1999, approximately $30 million *less* than in FY 1998, will place an intolerable strain on the medical system. Historically, an annual increase of about $1 billion has been needed just to cover the cost of inflation and other uncontrollable spending increases.

We are, of course, heartened that the Senate has now indicated willingness to exceed the President's funding request by S363 million with approximately $200 million more slated for health care and urge the House to provide for at least this additional funding level as well.

Once additional comment regarding direct VA health care funding over the past two decades. It was for the good of the nation that the VFW and veterans in general accepted VA funding levels that barely kept pace with inflation even as the cost of other non-veteran medical care programs, such as Medicare and Medicaid, grew many fold. During this period severe federal deficit spending placed such a strain on the American economy that it represented a threat to our very way of life. Just as when they served in uniform, veterans sacrificed to achieve a higher good. Now that the federal budget has been declared to be running a surplus we emphasize that no group is more worthy of benefiting from this situation than veterans.

It is for this reason we are outraged that the Congress and Administration have seen fit to pass a law denying VA for compensation for smoking related disabilities and, worse yet, use the scored savings of some $15.4 billion to pay for transportation pork. The benefits to potholes mentality displayed in this action denigrates the service and sacrifices of all of those who have served in uniform even as it deprives ill veterans of their just compensation.

The VFW is, of course, well aware that even with this nation's improving financial prospects, direct appropriation support alone will not suffice to make the VA all it should be. It is for this reason that we are so highly gratified that this Congress enacted into law a longstanding VFW priority goal—the authorization of VA to collect and retain third-party insurance payments for the medical it provides to insured non-service connected veterans. Unfortunately, VA is now falling behind schedule in its effort to to collect $604 million as called for in the President's FY 1998 VA Budget. There is a safeguard in law for this fiscal year providing that any third-party collection shortfall in excess of $25 million will be made up for with appropriated dollars. No such protection is in place for FY 1999. The VFW strongly urges that the congress make such a safeguard permanent. Such third-party collections represent a critical source of additional dollars, even though they alone will not make up for appropriations short falls. It is emphasized here that the VFW believes that the Administration's projection of $677 million in third-party collections for FY 1999 is grossly inflated, setting the stage for a catastrophic funding shortfall. We applaud position taken in the House Veterans' Affairs Committees' Views and Estimates funding recommendation for VA showing that expected collections will be considerably less.

Another important source of non-appropriated dollars in authorizing VA to collect and retain Medicare dollars for non-service connected health cares it provides to Medicare eligible veterans. Let me emphasize at many Medicare eligible veterans—especially among our military retirees—would prefer VA health care over private

sector providers. Unfortunately, current law prohibits Medicare from reimbursing VA for the medical services it provides to eligible veterans. This, in spite of the fact that these very same veterans may go to private sector providers and take their earned Medicare dollars with them.

This situation deprives veterans of the VA health care they need and desire while denying the system desperately needed additional funding. Medicare subvention for VA will allow more veterans to enjoy access to an expanded array of services while, due to VA's known cost effectiveness as compared to the private sector, the Medicare Trust Fund saves money in the process. We urge this Congress to make the enactment of legislation providing for Medicare subvention one of its top priorities and commend Chairman Stump for his hard work and initiative in negotiating a viable legislative vehicle toward this end in the form of H.R.

One of VFW's most pressing legislative goals is enabling VA to provide for the long term health care needs of America's veterans. As a group, veterans are aging at a more rapid pace than the general public. This means that the need for long term care services is now very much in evidence among these men and women and can only expect to rise. I now ask you, our nation's lawmakers, to work together with us in finding ways to meet the daunting task of meeting veterans' long term care needs now and in the future.

The VFW is a staunch supporter of America's woman veterans, and those women currently serving around the globe in today's armed forces. Women veterans deserve the highest caliber of health care yet many VA hospitals are not fully able to handle women-specific health problems. The VFW urges Congress to provide funding to VA for the improvement of hospital facilities and services for women veterans.

Mr. Chairman, once again on behalf of the men and women of the Veterans of Foreign Wars, I thank you for having involved us in this most important hearing today. This concludes my remarks and I will be happy to respond to any questions you may have.

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Testimony before The House Veterans Affairs Committee's Subcommittee on Health at Boise, Idaho June 30, 1998 by William R. Woodfin, Commander, Department of Idaho, Military Order of the Purple Heart.

I appreciate the opportunity to present my views regarding the effectiveness of the Boise VA Medical Center's programs in meeting the needs of Veterans.

I am a combat infantry veteran of WWII, having served as a replacement with The First Infantry Division in 1944. From the date I was wounded in November of 1944, I was moved off the field in Germany and taken to Belgium, France, England, and finally to a stateside hospital in February 1945. I was discharged on December 7, 1945.

I was rated at 40% disability from my chest wound and began my first experience with the Veterans Administration. From 1946 to the present, some 52 years, I have had the following experiences with VA:

1. Three exams as a result of my requests for consideration in disability rating increase.
2. Testing for aptitude and counseling to attend College under public law 16 of the GI Bill. Where I obtained my BS and MS Degrees.
3. Counseling regarding arrangements to make reduced payments on home loan to leave me sufficient funds to maintain my wife and four children while I was in school. With VA assistance at the Nashville Regional office, I was able to retain my VA home loan guarantee entitlement. I could not have expected better assistance and service.
4. About four years ago, I contacted the Boise Facility through the Idaho division of Veterans Services and under the assistance of Walter Jackson, one of the service officers in the office of Veteran Advocacy, I was evaluated upward to 60%.
5. In 1997, I contacted the Boise Facility again for an examination of my hearing. VA was unbelievably fast in making an appointment for me. I was extremely satisfied with the experience.

You will note that most of my experience has been mainly for services other than health care. Part, if not most of the times, I have needed health care and operations, I have chosen to use my own medical insurance and Medicare, because I felt I had paid on these programs and didn't choose to place the burden on our Veterans program.

I have had much experience with veterans since I have been a VFW Post Commander, a District Commander, and a Chapter Commander and as the First Commander of the Department of Idaho Military Order of the Purple Heart. I have been credited with recruiting and organizing these three chapters in Idaho, and the organizer of the Department of Idaho. In these activities, I have on many occasions, talked to Veterans,

their spouses and widows as well as sons and daughters in attempting to help them apply for Veteran's awards and to assist their family member in availing themselves of VA services. Included in these services, has been assisting them to understand that under many circumstances the Agency, like all federal and State agencies, have reasons for many forms and routine steps that are not always acceptable to persons not familiar with government regulations. I have seen where this has been beneficial to them as they got involved. It has been my experience that so often veterans are unwilling to do their own homework, many times their wives try to assist and often they lose patience.

I have regularly met with the Idaho Veteran's Council and the Division of Veteran's Services, and have participated in the programs at Idaho State Veterans Homes. I have learned a lot, and they have helped me understand the procedures. I have really tried to be a good Commander within VFW and MOPH.

While this is probably deviating from what your expressed interest is, I would be remiss if I didn't express my admiration for and confidence in the Idaho Division of Veterans Services, its administrator, staff and for the programs they administer. We as Veterans in Idaho are really blessed to have this State Agency and the wonderful cooperation that flows back and forth between VA and the State Agency. They cooperate so well; that many Veterans sometimes give one credit for a service the other has provided.

I have on a few occasions worked with a Veteran and his spouse, and have found some dissatisfaction. Mainly when this has been the case, I have tried to see if they had approached the correct office or individual.

Personally, my direct contacts and those of others with whom I have become involved indicate to me that VA in Boise does a fine job in carrying out their mandates. Again, personally at the Boise VA Facility and at other facilities, I have experienced some dissatisfaction with an exam that I was given by a specific doctor. He would ask you about your complaint and then present an attitude that he already had his mind made up and wasn't interested in what you told him. But I must hasten to say that in my experience, this type of situation has been minimal. In the cases that I experienced negativism, was with an older doctor who seemed to be tired and coasting out of his career. Another one was with a retired Navy doctor, who stated his convictions in no uncertain terms. I left with the feeling that his role there was to protect the government against Veterans who were trying to exploit the government. It was most alarming to me that an individual could believe that a Veteran who had given of his lifeblood unselfishly could be viewed as a person looking for a way to fleece the government and take advantage of the system.

I believe that recently VA has implemented some trial procedures that may have much merit. The preventative care, by sending Health Care personnel to the outlying locations such as the DAV hall in Twin Falls, of which I attended for a routine checkup. Another one is the correlating costs with other insurance programs of an individual. The regular meeting of a group to serve PTSD, at the National Guard Headquarters in Twin Falls is a program I want to attend.

The other program that I have heard a little bit about is the innovation of the VISN, which may be a good thing, but I am not informed enough to critique this. I have heard some concerns in the field about not being able to understand it, and that each seems to operate autonomously.

In complying with the letter from chairman Stearn, I have contacted Korean War Veteran Nyle Jones of Twin Falls to provide his testimony. Jones is the commander of the Twin Falls DAV chapter and he is a member of our chapter of the military order of the Purple Heart. He was wounded at the Chosen Reservoir and was a Prisoner of War. He has had much more experience with the VA hospitals than I have. I hope his views will provide more information about Boise.

In closing, Veterans everywhere look to our congressional body to provide the support and funding necessary to maintain the quality care Veterans deserve. They look to Congress to be the "watchdog" in this. In order that services provided to veterans truly "care for he who has borne the battle and for his widow and his orphan". And, veterans hope that Congress will bring the pay and benefits and dependants services to acceptable standards for our military personnel who now safeguard our freedom and that of other nations around the world. We must not continue to let them suffer from insufficient funding and inadequate health care and other benefits.

May God continue to bless America.

Thank you.

Testimony of Nyle Jones, Commander; DAV Chapter, Twin Falls, to the House Veterans' affairs Committee's Subcommittee on Health at Boise, Idaho on June 30, 1998.

Thank you for this opportunity to express my views regarding my experiences with VA medical facilities. I am a veteran of the Korean Was, a Sergeant in the U.S. Army wounded at the Chosen Reservoir, taken prisoner and held captive by the North Koreans from December 2, 1950 until repatriated on August 14, 1953.

I have been in the VA Medical system several times, mostly at the Boise facility. In January 1996 my personal doctor informed me that I had early stages of Hodgkin's Disease. In February I was sent to the VA medical facility in Salt Lake City. I was in the hospital until the middle of April. I couldn't have asked for better treatment than I got there. In December of 1983, I had a severe heart attack. I was in the Boise VA facility one month until the doctor there had me stabilized. Again I was provided the best of care. They flew me to Portland to the VA hospital. There the doctors and nurses treated me so kindly. I would never be able to thank them enough. In 1993 I had three aneurysms on my aorta. Again, I was given the best care by the surgeons in the Boise facility. The nurses would come to my room and ask, "how are you feeling sweetheart?" Those kind words always seemed to lift my spirits. In 1994 I had a hernia operation and received the same fine care and consideration. In 1995 I had to have another hernia operation on the opposite side. At that time they found three holes in my stomach and repaired them. The care was successful and great. Now it is 1998 and I have a blood clot behind my left eye, so I wonder "what's next"? I am scheduled to be in Boise on June 23, and I do not know whether they will perform surgery or not. Commander Bill Woodfin has agreed to read my paper to you in the event I am not able to appear before you.

For the past six years the Boise VA has provided a therapy group here at the Twin Falls National Guard Armory to help us with our PTSD which has helped all of us. My thanks go to all the VA hospitals that give Veterans such good care and with such kind and helpful treatment.

Thank You

Testimony of

Debra Smith

Board of Directors, National Gulf War Resource Center
Public Affairs Director, Idaho Desert Storm Foundation

Before the

House Veterans' Affairs Committee
Subcommittee on Health

June 30, 1998
Boise, Idaho

Honored Committee Members and Guests,

I would like to thank you for the opportunity to speak before you today. My name is Debra Smith and I am the spouse of a former Marine that became ill during his service in the Gulf War. His health problems were rated a combined 60% in early 1997, six years after his initial claim with the VA was filed. I am well aware of the complexities of Gulf War Illnesses as I am a member of the Board of Directors of the National Gulf War Resource Center and co-founder of the Idaho Desert Storm Foundation. The National Gulf War Resource Center is the largest national, nonprofit, Gulf War veterans organization, which is based in Washington, DC with a full time staff. My association with these organizations, and the veterans that comprise them, provides me with an insight into the broad issues affecting Gulf War veterans.

My message to this committee is one that is clear to those of us that interact daily with Gulf War veterans. It is a message of sensitivity.

Sensitivity is needed by VA physicians in understanding that the battlefields of Desert Storm were unique and unlike any conflict prior. The use of organophosphorous pesticides and carbamate pesticides as well as repellents such as DEET were widespread in the theater of operations. Environmental toxins such as oil fire byproducts, lindane, diazinon, depleted uranium and hydrogen sulfide provided unsafe living conditions.

For five years veterans questioned the likelihood that they had been exposed to chemical weapons during the Gulf War. For five years the Pentagon denied that possibility. When indisputable evidence was presented in 1996, those denials were turned to affirmation that almost 100,000 troops had been exposed to low levels of sarin and mustard agents during the destruction of Kamishiyah. Sensitivity is needed to grasp the betrayal these soldiers expeienced due to this incident. They had been scoffed at for years and now they facts they had presented were indeed true.

used when scheduling appointments, care given that veterans are not forced to travel several times during a month. Coordination of appointments by a case manager would optimize veteran's visits, reducing the amount of travel and lost wages.

I would like to suggest that sensitivity may help remove the tarnished image the VA has gained regarding the handling of Gulf War veterans illnesses. This blemish must be removed if the Veterans Administration ever hopes to regain the trust of those they have been charged to care for. A caregiver should be sensitive and understanding, not disbelieving and impassive of patient's complaints.

I close, by reminding the Congressional leaders and VA officials present, that those that served in the desert and returned home ill, are individuals that volunteered to ensure the values and beliefs of our great country were maintained. These are individuals of honor and integrity. And they deserve to be treated with respect. With sensitivity, you bestow that respect.

We believe that our concerns to ensure the best care available to Idaho Gulf War veterans can be achieved. We give credence to the presumption that Gulf War veterans were exposed to a variety of toxins during Operations Desert Shield and Storm, and that these exposures may be the basis for their unexplained illnesses. With independent research to prove which illnesses may be related to toxic exposure, service connection could be established. Two bills introduced by Congressman Shays provide for presumption of exposure to a multitude of toxins and the independent research needed to identify diseases related to those exposures. Myself, the Idaho Desert Storm Foundation and the National Gulf War Resource Center support the passage of H.R. 4036, the "Persian Gulf War Veterans Health Act of 1998" and H.R. 4035, the "Drugs and Informed Consent Armed Forces Protection Act of 1998". These bills provide the sensitivity needed to pursue the causes of Gulf War Illnesses objectively. Congressman, this is your opportunity to aide the Gulf War veterans. Provide the Veterans Administration the needed tools to render health care to ailing veterans by passing these bills.

Gulf War veterans' undiagnosbale ailments as never before have soldiers fought in such a toxic environment. Even my limited knowledge of synergistics lends belief that an exposure to a combination of the hazardous materials found in the Gulf War could have detrimental health effects.

Sensitivity is needed in understanding that this is a new generation of veterans. In the military history of our nation, soldiers deployed to the Gulf were on the average, older and better educated than ever before. Over 60% of those deployed to the Gulf were married. And these soldiers returned home heroes. Sensitivity must be used when the subject of PTSD (post traumatic stress disorder) arises. The VA has dealt with several generations of soldiers suffering from PTSD and still does not seem to understand the stigma attached to that diagnosis. Little is done to explain the association of physical and mental health. Families need to be included in mental health care as they seem to be the most impacted by a veteran's psychological suffering. Used as a tool, a spouse can be a healing mechanism, and should not be viewed as a liability by VA caregivers. Gulf War veterans fought a real war. They don't want to be sick. They want to be as they were prior to their deployment to the desert. They wish to have normal lives. They need sensitivity that their pain is real. VA care providers need to be sensitive of all the issues of Gulf War illnesses, of all the possible causes.

The complexity of Gulf War veterans health complaints necessitate the use of case managers. Case managers may provide the needed coordination for Gulf War veterans consults, test results and appointment scheduling. As they oversee the overall treatment of a veteran, they furnish a needed conduit for communication between consulting physicians.

Sensitivity is needed to realize that lost or misplaced records contain extensive medical histories and such losses halt treatment until the files can be reconstructed and tests repeated. As Idaho's population is largely located in rural communities throughout the state, many of our veterans must travel great distances for VA care. Sensitivity should be

Thank you, again, for the chance to speak before you. And for your concern for those that served our nation proudly when called.

Testimony of

Arthur F. Boyle

Vice President, Fleet Reserve Association Branch 382,

Member Council of the Fleet Reserve Association of the State of Idaho

Before the

HOUSE VETERAN'S AFFAIRS COMMITTEE'S SUBCOMMITTEE ON HEALTH

June 30, 1998

Boise, Idaho

Honorable Committee Members and Guests,

I would like to thank you for the opportunity to speak before you today. My name is Arthur F. Boyle and I am The Vice president of the Fleet Reserve Association Branch 382 as well as a member of the Council of the Fleet Reserve Association of the State of Idaho. Virtually all of our 160,000 national and approximately 750 state members as well as their families are registered voters. I served our country during World War II and Korea. I retired from the U.S. Navy on April; 15, 1959 as a Chief Hospital Corpsman after 21 years of service. With all of my vascular problems I am rated 60% disabled. I have been and still am an out patient of the Veterans Administration Medical Center in Boise.The treatment that I have received has been outstanding throughout the years including the superb treatment I received when I had a cerebral accident [stroke] on May 1st, 1991. During that time I was Hospitalized and had surgery on my left carotid artery and afterward rehabilitative treatment.

My message to this committee is one that is crystal clear to those of us who have served and are now serving our country when called upon, wherever that may be. We have been and are now supported by our families even though when we were on active duty we may have spent months or years before we saw them again. It is a message of Concern and Disappointment, and yes in some cases even of Disgust.

Concern for the lack of access for retired servicemen and women to V.A. facilities unless they are destitute or have service connected disabilities making it impossible for a large portion of career servicemen and their spouses to be able to support and use V.A. Hospitals.

Disappointment in the cancellation of "Champus" and transfer to medicare at age 65 in violation of promises made to us, by recruiters, as an incentive to reenlist that were made to me and my fellow shipmates when we were solicited by our various branches of service to pursue the military as a just and honorable career.

It is disheartening when we hear that monies are not available to "make things right" and at the same time read about hundreds of thousands of dollars given to foreign nationals that were killed by friendly fire while our own casualties are ignored, or the $200,000 tax break given to estate taxes for those who have an estate of over 17 million dollars which may cost the treasury $880 million in revenue in the next 10 years [as reported by"Molly Ivens", a columnist of the Fort Worth Star-Telegram and published in the Idaho Statesman Commentary section on June 27, 1998].

In conclusion, even though "subvention" demonstration projects are authorized finally, it is hard to accept and disappointing to say the least, to realize that our nation can help save the world, but is unwilling to care for it's veterans who have led her to victory time and time again throughout our history. Yet, seems to care more for a civil service worker who may have never seen combat or been in harms way. It would seem that at least equal treatment in health care would not be asking to much.

Thank you again for the opportunity to speak before you in behalf of my fellow shipmates and their families and your concern for those of us who have served and are now serving at your pleasure.