

**REVIEW THE PROVISION OF SPECIALIZED SERVICES AT THE DEPARTMENT OF VETERANS AFFAIRS**

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**HEARING**  
BEFORE THE  
SUBCOMMITTEE ON HEALTH  
OF THE  
COMMITTEE ON VETERANS' AFFAIRS  
HOUSE OF REPRESENTATIVES  
ONE HUNDRED FIFTH CONGRESS  
SECOND SESSION

—————  
JULY 23, 1998  
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Printed for the use of the Committee on Veterans' Affairs

**Serial No. 105-45**



U.S. GOVERNMENT PRINTING OFFICE

53-427CC

WASHINGTON : 1999

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For sale by the U.S. Government Printing Office  
Superintendent of Documents, Congressional Sales Office, Washington, DC 20402  
ISBN 0-16-057993-7

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# REVIEW THE PROVISION OF SPECIALIZED SERVICES AT THE DEPARTMENT OF VETERANS AFFAIRS

THURSDAY, JULY 23, 1998

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

The subcommittee met, pursuant to notice, at 9:30 a.m., in room 334, Cannon House Office Building, Hon. Cliff Stearns (chairman of the subcommittee) presiding.

Present: Representatives Bilirakis; Cooksey; Hutchinson; Peterson; Gutierrez; Evans; and Brown.

## OPENING STATEMENT OF CHAIRMAN STEARNS

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

This morning's hearing brings to mind a question which critics and interested parties raise from time to time. Namely, they ask us why Congress continues to provide service to veterans through a government-run healthcare system.

In my view, an effective response to that question must include a discussion of VA specialized treatment and rehabilitation programs. VA's expertise in the care and rehabilitation of veterans disabled by spinal cord injury, chronic mental illnesses, blindness, and post-traumatic stress disorder are at the core of what makes VA a unique healthcare provider, one which Congress continues to support. Not surprisingly, therefore, when VA proposed a major restructuring of its healthcare system several years ago—one of the important concerns this committee raised was the future of its special disability programs.

At a hearing before this subcommittee in April 1995, Members asked what steps the VA's Under Secretary of Health, Dr. Kizer, would take to insulate these programs from cost-cutting. Dr. Kizer offered no specifics. His general assurance did little to allay the widespread concern that reorganization and restructuring would result in downsizing or even eliminating these important, but often costly programs.

Accordingly, 2 years ago, this committee adopted legislation to require the VA at least to maintain its capacity, to provide for disabled veterans' needs through distinct specialized programs and facilities. That legislation enacted in October 1996, also required consultation with two consumer-focused committees and annual re-

porting to Congress to monitor compliance. This legislation was hailed by disabled veterans and their advocates. But its enactment has not quelled their concerns. I, too, am concerned that vital programs are being eroded. I called this hearing to ensure that these key programs get the priority, funding, and staffing required by law.

I've reviewed VA's most recent report to Congress on maintaining the service delivery capacity of these special programs. Let me underscore my deep concerns.

I'm concerned that one of the expert committees with which VA was to work in implementing this law questions the validity of the data VA has provided Congress.

I'm concerned that 2 years after enactment of this law which was viewed as critical to safeguard these vulnerable programs, VA's data does not provide a reliable basis to determine whether there's been compliance with the law or not.

I'm concerned that in giving the VISN Directors flexibility in meeting the law's requirement, VA's top leadership has done a lot of trusting, but not a lot of verifying.

I'm concerned that too many of those charged with carrying out the law may be looking too closely at the bottom line and not carefully enough at the well-being of those who depend on these unique programs.

I'm concerned that the clear intent of Congress to insulate vital programs from cost-cutting may have been ignored or at least variably applied in some of the VA's 22 networks.

The VA has certainly made impressive strides in healthcare delivery in recent years. But these special programs are what make VA unique and are critical to vulnerable, disabled veterans. VA leadership must work a lot harder, in my view, to ensure that they are preserved.

I look forward to this morning's testimony. But before going further, I'd like to call on the ranking member, Representative Gutierrez, for any opening comments he may have.

#### **OPENING STATEMENT OF HON. LUIS V. GUTIERREZ**

Mr. GUTIERREZ. Thank you, Chairman Stearns. Our Constitution established the framework for government that has served our Nation well for more than two centuries. In that esteemed document, roles for the three branches of government were defined. Under the Constitution, Congress is given the responsibility to make our laws and the Executive Branch was charged with administering their implementation. Today, I believe we are examining a case where the long-held relationship has broken down.

In 1996, Congress approved, and President Clinton signed, the Veterans' Healthcare Eligibility Reform Act. Contained in this legislation is section 1706(b)(1) of title 38. This provision mandated that the Secretary of Veterans Affairs ensure that the VA maintains its capacity to provide for specialized treatment and rehabilitative needs of disabled veterans, including veterans with spinal cord dysfunctions, blindness, amputation, and mental illness.

After carefully reviewing the available information regarding the specialized and rehabilitative services, and after hearing from members of the veterans' community—both here and in my dis-

trict—I have concluded that the VA is currently failing to properly adhere to the stipulations mandated by Congress in section 1706. The VA's specialized and rehabilitative programs have been detrimentally affected by the VA decentralized structure, budget constraints and resource allocation formulas. The specialized and rehab programs have not been adequately protected by the VA. This is not to say that reform of the VA system is altogether damaging to the future of the veterans' healthcare. It is not. Reform is critical to the VA's future. The VA's recent reforms have led to greater efficiencies and savings in many areas of the veterans' health care system.

Nevertheless, what Congress feared in passing section 1706 was that the VA reform would threaten the more expensive inpatient base in long-term care specialized services that provide vital care to the most vulnerable veteran population. Congress' fears have come true despite our best intentions in 1996. Its spinal cord centers, geriatric research centers, substance abuse wards throughout all the specialized services—cutbacks have worsened the quality of care. Much of this stems from individual decisions made at the VISN (Veterans Integrated Service Networks) division level. Expensive costs of providing spinal cord care or to address the healthcare needs of blind veterans makes these programs particularly difficult to maintain in business where budget restrictions force major streamlining.

VISN Directors, with salary bonuses based on how much they have saved annually, are provided with incentive to neglect specialized programs under their administration. Doctor and nurse positions go unfilled. Waits for treatment are extended and quality of care declines. This situation that has occurred throughout our Nation requires the immediate attention of the VA and this committee.

I believe that we need a greater direct oversight of the administration of specialized programs, including the hiring of full-time coordinators in each division and on Vermont Avenue. Consolidating program budgets and taking the specialized services out of the model division funding pool should also be contemplated. If not, I believe, that Congress will have to take further legislative steps to ensure that section 1706 is being implemented.

I have two final points. First, the VA exists primarily to ensure that our most vulnerable veterans receive the healthcare and compensation they have earned in risking their lives for our Nation. Whether the VA adopts private sector models or not, reforms or fails to, seeks out a new patient base of non-category aid veterans or structures its services around current eligibility standards should not affect this basic mission of the VA.

Second, I have focused this morning on the inability of the VA to ensure that specialized services are being maintained as Congress charged. But I would be passing the buck if we did not point out that Congress is responsible for the problems we are discussing today. This Congress, the 105th, has underfunded the VA by more than \$500 million. This Congress and the administration have pushed VA funding downward for nearly 5 years. Common sense dictates that when spending is tightly constrained, budget over-

sight is decentralized and cutbacks are forced at VA medical centers, the most vulnerable veteran will be the first to suffer.

When we in Congress disparage VA administrators and directors for the declining level of care veterans receive in various parts of our Nation—which we are prone to do—let us remember that we, Congress, have created this climate. That we, Congress, have slashed budgets that affect the specialized services. We, Congress, should look first to what we can do to adequately fund veterans' healthcare before we blame the VA.

Mr. Chairman, my mother explained to me when I was young in life that you reap what you sow. We should all heed this wisdom when considering our responsibility to America's veterans. Thank you.

Mr. STEARNS. I thank the ranking member.  
Now the first panel will come forward.

#### OPENING STATEMENT OF HON. MICHAEL BILIRAKIS

Mr. BILIRAKIS. Mr. Chairman, we do not have the—

Mr. STEARNS. Oh, I'm sorry. My good colleague from Florida, Mr. Bilirakis.

Mr. BILIRAKIS. Thank you, sir. Mr. Chairman, first I, too, want to commend you for scheduling today's hearing on the VA's efforts to maintain specialized healthcare services. With the enactment of the Eligibility Reform Act of 1996 and the other major changes taking place within the VA healthcare system, this is an important issue that deserves our attention.

Over the years, I've had a very strong interest in the VA's specialized services, particularly the services for veterans with spinal cord injury or dysfunction. I don't think that's too much of a surprise to anyone. When Congress approved the Veterans' Healthcare Eligibility Reform Act, we included language mandating that the VA maintain its capacity to provide specialized healthcare services to veterans. I'm very concerned, as others have already said, that the VA may be ignoring—and if not ignoring—certainly not living up to our directives. In reviewing the testimony of our witnesses, it's clear that I'm not alone.

In part, my concerns also stem from my continuing frustration over the construction of a SCI Center at the James Haley VA Medical Center in Tampa, FL. The VA first proposed expanding the current SCI Center in 1971. The existing center has one of the highest demands for SCI services in the VA system, but it suffers from major space deficiencies and safety violations. It's been over 25 years, Mr. Chairman, and Florida's veterans are still waiting for the new SCI Center to be constructed. I might add the current SCI Center was originally intended to be a psychiatric ward. It was certainly not designed for SCI purposes.

Given the VA's continuing reluctance to fund this much needed facility and the other issues raised by some of today's witnesses, I, unfortunately, have to question the VA's commitment to maintain these specialized services. In my opinion, Mr. Chairman, the VA's specialized services are the heart of its healthcare mission. In fact, constantly in these hearings, we get VA witnesses using that as a reason to continue the need for separate veterans' healthcare, rather than mainstreaming. So it's incumbent upon us as Members of

Congress to make sure that these services are available to the brave men and women who have served our country. Like you and the others, I look forward to hearing from our witnesses and look forward to working with you and other Members on this very important issue. Thank you, Mr. Chairman.

Mr. STEARNS. That was excellent. Thank you. My colleague, Mr. Hutchinson.

#### OPENING STATEMENT OF HON. ASA HUTCHINSON

Mr. HUTCHINSON. Thank you, Mr. Chairman. I appreciate you showing leadership to hold this hearing. I am looking forward to the testimony of the witnesses. I think there is one simple question that has to be addressed. That is, whenever the VA is serving more veterans with special disability problems and in those categories, and yet we are spending less—is that a reflection of good management or is that possibly an indication of the lack of good care going to these special disability groups? So that's a very critical question that has to be answered. I look forward to hearing the testimony of the witnesses as they address that question. So I yield back, Mr. Chairman, and look forward to this testimony today.

Mr. STEARNS. I thank my colleague. I guess there's no more opening statements; we'll have the first panel come forward.

We have Stephen Backhus, the Director of Veterans' Affairs and Military Health Care Issues, Health, Education, and Human Services Division of the U.S. General Accounting Office; Richard McCormick, Ph.D., co-chairman, Committee on Care of Severely Chronically Mentally Ill Veterans, and Mr. Thomas Miller, Chairman of the VA Advisory Committee on Prosthetics and Special Disabilities Programs.

Let me welcome you folks here. I appreciate your taking the time this morning. We'll open with Mr. Backhus. Your opening statement.

#### STATEMENTS OF STEPHEN BACKHUS, DIRECTOR, VETERANS' AFFAIRS AND MILITARY HEALTH CARE ISSUES, HEALTH, EDUCATION, AND HUMAN SERVICES DIVISION, U.S. GENERAL ACCOUNTING OFFICE; RICHARD McCORMICK, Ph.D., CO-CHAIRMAN, COMMITTEE ON CARE OF SEVERELY CHRONICALLY MENTALLY ILL VETERANS, AND THOMAS H. MILLER, CHAIRMAN OF THE VA ADVISORY ON PROSTHETICS AND SPECIAL DISABILITIES PROGRAMS

##### STATEMENT OF STEPHEN BACKHUS

Mr. BACKHUS. Good morning, Mr. Chairman and members of the subcommittee.

I'm pleased to be here today to discuss our ongoing evaluation of VA's efforts to ensure systemwide capacity and reasonable access to specialized treatment and rehabilitative services. You asked that I focus my remarks on two issues—whether VA is maintaining capacity with reasonable access to specialized care and whether VA has data that is sufficiently reliable to monitor and report on compliance.

My comments are based on meetings we've had with VA, VSO and advisory committee officials, as well as a review of VA and ad-

visory committee reports. We will be continuing our work over the next several months and expect to issue a report next spring.

In summary, our work to date suggests that much more information and analysis is needed to support VA's conclusion that it is maintaining its national capacity to treat special disability groups. While VA's data indicate that overall the number of veterans served has increased by 6,000, or 2 percent, between 1996 and 1997, the data also show the total spending for specialized disability programs decreased by \$52 million. The number of veterans treated systemwide for conditions such as amputations and substance abuse has decreased, as have expenditures for veterans with amputations, serious mental illness, PTSD, and substance abuse.

VA attributes decreased spending to reducing duplicative services and replacing more expensive hospital inpatient care with outpatient care. It is too early for VA to assert that capacity has been maintained without knowing how effectively these dollars have been spent. Similarly, positive indicators of improved access for five of the six special disability programs also warrant more review. For example, the proportion of veterans receiving psychiatric outpatient care within 30 days of hospital discharge increased by a negligible .6 of 1 percent in 1997. The monthly waiting time for admission to the inpatient blind rehabilitation program increased by 1 to 8 weeks for 11 months of the year.

Consistent with the Government Performance and Results Act of 1993, VA plans to develop outcome measures over the next 2 to 3 years to track whether the care provided to disabled veterans is effective as a result of its shift to outpatient care. VA intends to replace expenditure data with outcome measures when they become available. While we fully support the addition of outcome measures to evaluate the effectiveness of physical, psychological, and social services, we also believe that current measures such as dollars spent serving veterans' special needs are also important to gauge legislative compliance.

Moreover, other data, not now used by VA, such as the number and type of specialist providers, and the number of beds may also be useful indicators of capacity. Additional analysis is also needed to fully explain the large regional variations in the number of patients served. Beyond the issue of capacity measurement, however, we also have questions regarding the reliability of VA's data. VA's reduction of its reported 1996 baseline expenditure data, without explanation, is a critical issue for us to review. In all six programs and services, VA reduced the baseline. In one program, by as much as 50 percent in each VISN facility and in another by \$56.5 million. VA's two advisory committees have also raised questions that you'll hear about today, I think, regarding anomalies in the capacity data identifying—for example, a questionable increase in expenditures at one facility of 3,500 percent over one year. VA has acknowledged the need to improve its data systems and has several efforts underway to do so.

In conclusion, Mr. Chairman, the VA strives to measure compliance with the requirements of the Eligibility Reform Act. It needs to develop more comprehensive data and improve the reliability of existing information. We will continue to assess VA's efforts as we complete our study. Mr. Chairman, this concludes my remarks. I'll

be happy to answer any questions you or other members of the subcommittee may have.

Mr. STEARNS. Thank you, Dr. McCormick.

[The prepared statement of Mr. Backhus appears on p. 50.]

#### STATEMENT OF RICHARD A. McCORMICK

Mr. McCORMICK. Yes, thank you, Mr. Chairman. Approximately 1.7 million veterans meet the consensual definition for seriously mentally ill. About 300,000 of these use VA services. It is most appropriate that the capacity report monitor the care of veterans with serious mental illness and post-traumatic disorder. Over 450,000 veterans have been adjudicated to have mental disorders related to their military service. Over 100,000 were combat-related post-traumatic stress disorder—a disease which goes to the very core of the primary mission of VHA.

This is a tumultuous time in healthcare. Services for the seriously mentally ill are at risk during such times of change. These patients have disorders which are complex, disabling and chronic in nature. The data presented in the report on the number of services show the national increase of 1 percent for veterans with serious mental illness and PTSD and a decrease of 2 percent for seriously mentally ill substances abusers. This contrasts with a 3.8 percent overall increase in all veterans served by VA. This relative slower growth and in the case of substance abuse decline, can't be simply attributed to lack of opportunity to provide such care.

In 1997, VA provided mental healthcare to only 38 percent of those who are service-connected for a mental health disorder, and only 8 percent of the total of low-income service-connected veterans. Local rates of variation and local rates of utilization vary widely and we related very much to the distance that a veteran lives from an access point. The capacity report shows declines in expenditures of 3 percent for the seriously mentally ill; 7 percent for post-traumatic stress disorder; and 20 percent for seriously mentally ill substance abusers.

This decline must be compared to a 5 percent overall increase in funding for VHA services during the same period of time. Decreased expenditures are, in all cases, the result of decreases in inpatient care. The Committee on the Care of Severely Chronically Mentally Ill Veterans is supportive of de-institutionalization of the chronically mentally ill and the movement towards outpatient care for substance abusers. If accomplished appropriately, such efforts can increase the value of mental health services. The available data, however, caused grave concern as to whether such a transition is being consistently managed throughout VA. It would be expected that the transition for more expensive inpatient care would result in the ability to treat significantly greater numbers of seriously mentally ill, non-users of VA services.

Of equal concern to the committee is the large variation among networks. We consider that true access implies reasonable access across the country; where a veteran lives shouldn't determine the availability of services. Decreases in specific networks in the numbers of patients served was as high as 35 percent for post-traumatic stress disorder; 28 percent for homeless seriously mentally ill; and 13 percent for seriously mentally ill substance abusers.

The current available data are inadequate to comprehensively monitor VHA's efforts to maintain capacity. For example, existing administrative databases do not indicate whether an adequate array of services are in place to successfully reintegrate the institutionalized, seriously mentally ill patients into the community. The rapid de-institutionalization needs to be accompanied by the development and deployment of intensive community-based services. There has, unfortunately, been little growth in the number of these programs in VA. Over two-thirds of VA facilities still do not have intensive community case management services for the seriously mentally ill.

Furthermore, VA has begun the rapid development of a large array of community-based outpatient clinics. Most of these clinics are actually targeted for geographic areas where the utilization of VA services by high-priority seriously mentally ill veterans is low. As of January, 144 community-based outpatient clinics had been approved by Congress. Unfortunately, less than 40 percent of these included basic mental health services. These clinics could afford an ideal opportunity for VA to maintain its commitment to the care of the seriously mentally ill by utilizing at least a portion of the funds saved through inpatient reductions to provide outpatient care for seriously mentally ill veterans near where they leave.

In summary, the number of seriously mentally ill served has not kept pace with the overall growth of VA; fewer dollars are being spent on their care. There is unacceptable variation across the system. There is no evidence, that nationally the expected growth and intensive community and outpatient programs has accompanied the closure of inpatient programs. Most VA new access points do not address the unmet demand for services for even the highest priority seriously mentally ill.

The committee feels that continued vigilance supported by better data is required to assure that VA does not decrease its commitment to the seriously mentally ill and to veterans with combat-related post-traumatic stress disorders. Thank you, Mr. Chairman.

[The prepared statement of Mr. McCormick appears on p. 61.]

Mr. STEARNS. Thank you. Mr. Miller.

#### STATEMENT OF THOMAS H. MILLER

Mr. MILLER. Okay. I thought my hearing aid battery—

Mr. STEARNS. No, no. Let me apologize. I just didn't have my microphone on—it's my fault.

Mr. MILLER. In fact, audiology is one of those programs under our advisory committee's jurisdiction. I'll have to get new batteries, but—

(Laughter.)

Mr. Chairman, I want to thank you on behalf of the Secretary's Advisory Committee on Prosthetics and Special Disabilities Programs for inviting us to participate in this extremely important hearing this morning. It's a real honor for me to represent our committee—both the current members and those who have served over the past 7 years. We've had a very distinguished number of individuals that have served on our committee, and have a great deal of expertise and experience in the treatment of special disabilities and in the rehabilitation field generally.

We've had a rather diverse membership in our committee—individuals from the private sector, individuals from the VA, from the academic community, as well. As you are aware, we have three veteran service organizations—the Paralyzed Veterans of America, Disabled American Veterans, and Blinded Veterans Association—who are permanent members of that committee. I've had the pleasure of serving on that committee since its inception. Our first meeting was held in July—7 years ago.

I think it might be helpful to review a little bit the history of the committee, at least in terms of the problems that led to the establishment of our advisory committee. As I believe you're all aware, the Senate Committee on Veterans' Affairs conducted an oversight hearing in 1990 focusing on prosthetics and special disabilities programs. Many, many very serious problems were uncovered in that hearing, principally in the area of timely, high-quality delivery of prosthetics services. Many other problems were identified in terms of rehabilitation, research, and development service within VA, blind rehabilitation service, specifically unconscionably long waiting times and waiting lists for admission to rehabilitative services, and an assortment of other issues.

As a result of that oversight hearing, our committee was established. There were a number of very positive outcomes or gains that were realized as a result of that hearing in the following several years. Principally, centralized funding was established to fund the prosthetics service program. Prior to that time, the funding of prosthetics services had been decentralized to the region and to the local levels. There was a good deal of evidence to suggest that dollars that were being allocated for prosthetic services were being utilized at the local level to provide services other than the provision of quality and timely prosthetics.

In addition to the centralization of the funding, there was a significant increase in professional staff added across the system; namely, in the form of prosthetic representatives or prosthetic chiefs. New services were established in a number of VA facilities that did not have a full prosthetic service up until that time. Additional staffing was provided for headquarters. The staff in headquarters in conjunction with VA management and in the Congress established what they called the prosthetic improvement implementation plan. It defined a number of very specific goals that needed to be achieved within specific timeframes. We were very pleased on the committee that—and we receive reports on a regular basis regarding their compliance with the PIIP—they made great strides. Many of the problems that existed in prosthetic service diminished almost completely. They were very effective in managing the money, applying it to the purchase of prosthetic services in a timely way.

We, also, were pleased to note that problems in rehabilitation research and development service were similarly resolved and demonstrated significant improvement. Some improvement was also noted in blind rehabilitation service with the provision of additional resources across the system to bring all the blind rehab centers up to their full staffing levels. Therefore, they were able to operate all their authorized beds and reduce the length of wait for veterans

who had applied for training because they were able to operate much more efficiently.

I present that background to put into perspective our current view of the status of all of these programs following the transition—the new VHA, if you will—from a hospital-based system to an ambulatory managed primary care model of delivery. Unfortunately, the committee is quite concerned that we've seen some erosion in the gains that have been achieved as a result of the 1990 oversight hearing. Most notably, prosthetic service and blind rehabilitation service have taken the biggest hits, if you will. We have noted that in prosthetic service and they've realized—since 1995—they've experienced a 67 percent increase in workload, while at the same time, they've experienced significant loss in staffing levels.

Their ability to provide timely, quality service has been severely compromised. One of the measures for that was a delayed order report that facilities submit to headquarters on a monthly basis. Since this time last year, there's been a 74 percent increase in the delayed orders being reported. There's over 8,300 delayed orders as of the end of the second quarter of this fiscal year. Clearly, there's a fiscal problem in that there aren't adequate dollars to support the prosthetics program. Medical centers are finding themselves in a very difficult position identifying sufficient funding to support these programs. Until this final quarter, the way they were doing that was borrowing from their—against their—next quarter allocation. Now that we're in the fourth quarter, there is not another quarter to borrow against. So we expect delayed orders to increase dramatically and the veterans to go without the necessary prosthetics appliances.

Prosthetic service is also experiencing extreme difficulties in the field in retaining highly qualified professionals and their services. Their grade structure is not adequate to recruit and retain folks. The organizational realignment that's occurred as a result of the transition to 22 networks with decentralized management has resulted in a great deal of inconsistency throughout the system with how prosthetic services and other services are organizationally aligned and treated within their facilities and/or networks.

Just as an example, the Director, the Chief of the prosthetic service at the VA Medical Center in Denver, following a national training center went back home and was so frustrated, he resigned and took a purchasing agent position, six grade levels below. He felt that he couldn't get the support from this facility, he couldn't get adequate staffing. The staff that he was able to retain were burned out. This is not an isolated incident. It's occurring more and more frequently across the system. Clearly, there needs to be greater sensitivity, recognition, of a problem and the willingness to try and do something about it. We feel that that has been lacking to this point.

The other two witnesses refer specifically to the capacity report and the data included therein. Our committee, as you know, did not endorse the capacity report that was sent to Congress. We felt the data was flawed, it was confusing, it was disorganized, and unreliable. We believe the VA—the VHA—is moving in the proper direction with regard to data collection, but the information management systems are not there yet. However, they're basing decisions

on inadequate and inaccurate data. Dr. Kizer repeatedly has emphasized that this new system would be one that would be a data-driven management system and decisions would be driven by data. Inaccurate or invalid data is not going to help the decisions that are being made in the field.

Blind rehabilitation service is experiencing some difficulties as a result of the reorganization and the allocation methodology. I will be coming back on another panel and we'll focus more in-depth on those specialized services for blinded veterans, but it is a problem that our committee has been intensely following. It's been a chronic problem. The erosion of resources and the involvement of our program managers at headquarters with a field leaves an awful lot to be desired. These are national programs, Mr. Chairman, especially prosthetic services which cuts across all the disability groups.

My final comments are related to the impact, I guess, of the Eligibility Reform Act and we appreciate the efforts of your subcommittee and the full committee in getting that legislation crafted and moved through the Congress—one of the unfortunate, I guess if you will, from VA's standpoint, effects of that is the increased demand for prosthetics and the increased budgetary implications that has had, particularly in the area of ophthalmology and audiology, speech pathology, their workloads have increased dramatically. Without any appreciable increase of staff to provide service, the workloads have just become incredibly large. Without relief from a resource standpoint, veterans are going to wait longer and longer for those services and for the necessary prosthetic appliances and aids to help them overcome their disabilities.

Mr. Chairman, that concludes my statement and I'd be more than happy to answer any questions that I can.

[The prepared statement of Mr. Miller, with attachment, appears on p. 66.]

Mr. STEARNS. Thank you, Mr. Miller. What we're trying to do is understand whether it's management here or budget reductions. I think all of you have mentioned sort of the inconsistency from each VISN to VISN. Before I go further, Mr. Backhus, how far are you into your GAO report?

Mr. BACKHUS. We began 2 months ago. I would say about one-fourth of the way through.

Mr. STEARNS. About 25 percent?

Mr. BACKHUS. Yes.

Mr. STEARNS. When do you think it will be complete?

Mr. BACKHUS. We're estimating that next Spring we'll have a final report, but really we'll have most of the analysis done late Winter.

Mr. STEARNS. In the first part of your report, are you finding, from VISN to VISN, the inconsistency in delivery servicing of veterans in the disability group?

Mr. BACKHUS. Tremendous variation.

Mr. STEARNS. Is this variation management-driven or is it, for example, that the delivery of services with outpatient clinics—as you say in your statement—has impacted some of the VISNs. Isn't that true?

Mr. BACKHUS. Absolutely.

Mr. STEARNS. Yes.

Mr. BACKHUS. That's consistent with the nationwide shift toward more outpatient care. It's both. It's not just in the way care is delivered, but it's the management and the emphasis that's placed on particular programs. That's where variability seems to be less explainable and what we're really going to try to understand better.

Mr. STEARNS. Dr. McCormick, how would you explain the marked differences that appear in this consistency of delivery of services from VISN to VISN? How should the VA respond to these regional differences and how can we be sure that we're maintaining the program consistently?

Mr. MCCORMICK. Well, we start, of course, from a point of considerable variability. Some networks clearly do have budgetary reductions. Although again in a given year's period, those are capped and are nowhere near the 20 to 30 percent range of reduction in patients served that we see in some networks. The networks also vary very much initially in how many patients they have in inpatient settings. Nevertheless, we on the committee don't necessarily expect that even dollars will remain constant in every VISN. We recognize that as facilities go from inpatient to outpatient modes, they should be able to operate more efficiently. What we find very difficult to understand is that in some of those very networks where the dollars go down, the expected increase in numbers don't go up.

To answer your question as to why there's variability. I think one thing that needs to be borne in mind is that the networks, perhaps understandably, have very different systems on how they manage mental healthcare. Some of them have a much more centralized network system where there is a single person or single body who oversees mental health services. Others continue to rely more on individual facilities. Again, one of the things we're very concerned about is that the growth to outpatient access points is, again, inconsistently including mental health services. There are some networks where every community-based outpatient clinic has mental health services and there are some where almost none of them do. These are clearly management decisions—that particular example is clearly a management decision.

Mr. STEARNS. So I think what you're saying is that the variability between the different VISNs is primarily a management problem.

Mr. MCCORMICK. Well, I understand that part of it is driven given a VISN that's losing money. It's more complicated. If you're in a VISN that perhaps starts with a very heavily institutionalized population, it is more problematic. But I think, in my opinion, there is a lot of the variability that is due to management decisions.

Mr. STEARNS. How would you grade the VA compliance, both at the VISN level and the national level? Is there any way you can do that?

Mr. MCCORMICK. Well, again, the numbers, when you look at the numbers in the report and again these numbers are administrative data and don't tell the full story. The committee was glad to see that there weren't huge decreases in the number of patients seen. As a system, I think that based on the available data and taking very much into account what we still haven't seen in terms of

movement towards community-based and intensive community outpatient approaches, I guess I would give the whole VA maybe a "C". But there are networks that probably deserve an "A" and there are those that probably deserve a "D."

Mr. STEARNS. No one's flunking?

Mr. MCCORMICK. Well, I don't have enough data to—when I teach I'm very careful only to flunk people if I really have good data.

Mr. STEARNS. Well, this might be a little tougher question. Should we continue to require the VA to maintain the "capacity" of these programs from VISN to VISN?

Mr. MCCORMICK. I absolutely think we should. Again, my view and the view of the committee is that these are populations who often don't have a voice especially the chronically and severely mentally ill—the psychotics. There are over a 136,000 veterans who are service-connected just for psychosis, which is the most disabling of the mental disorders. They have no voice. I don't think they often have a voice even within the networks. There needs to be vigilance to make sure that they don't get lost in the sweep towards making the system more of a healthcare system, which I think again, in my view, is a good move. I think the VA does need to move from being a hospital system to a healthcare system. We just need to make sure that as we do so we develop a healthcare system for the seriously mentally ill, as well.

Mr. STEARNS. Would you repeat that last part? You believe it should be moved from a hospital care system to a what?

Mr. MCCORMICK. A healthcare system. I mean, I really do support going away from a series of hospitals to really looking at a population of patients who need care and trying to increase access to further impact a larger number of patients. Again, the figures that only 38 percent of those who are service-connected for a mental illness receive VA care shows that we have a long way to go to bring care closer to where patients live to take a healthcare system approach. So again, I'm very supportive of VA's move to become a healthcare system, rather than just a set of hospitals. I think the committee is also concerned that as we get out there and develop new access points, get into the community, the resources we save on the hospitals for the seriously mentally ill need to be redeployed out to these new access points.

Mr. STEARNS. Mr. Miller, would you agree with Dr. McCormick on what he said, moving from a healthcare hospital system to healthcare delivery system?

Mr. MILLER. Yes, sir. I think, there was no question that the VA needed to change the way they were providing healthcare. That a hospital-based system is not the most efficient or economically sound way of providing comprehensive quality healthcare to our Nation's veterans. I would have one caveat. However, there are certain programs that do need, and are very effective as inpatient, residential programs that need to be maintained. Not everything can be placed out in community-based outpatient clinics who are in some kind of an ambulatory care setting. Very careful decisions need to be made regarding what programs are suitable and appropriate and will result in desired outcomes in an ambulatory setting as opposed to an inpatient setting, and to ensure that those that

require inpatient services, those services are there for those veterans who require that type of service.

Mr. STEARNS. Thank you, Mr. Miller. That concludes my questions. Now the ranking member, Mr. Gutierrez.

Mr. GUTIERREZ. Thank you, Mr. Chairman. Mr. Backhus, in your judgment and given the information you have at this time, do you think that the VA is ensuring its capacity to provide specialized services to veterans? Do you think it's at the same level as it was in October 1996?

Mr. BACKHUS. I suspect it's mixed, varying by program and, of course, by region. Overall, it's impossible to say. It's impossible to know at this time. I don't think that this Congress has the assurances that they expected to have from VA through this legislation. There clearly is additional information that I think is available, that ought to be made part of the reporting requirements of VA, that would give you those answers. But I haven't seen that information yet. We're focusing on that over the next several months and hopefully we'll have that answer, ultimately.

Mr. GUTIERREZ. Following up on information and where we should be getting our information—pools of information—the GAO questions the reliability of the VA's data. But you're going to use it. If the VA's data is faulty or at least questionable, could you just share with us what other sources of information you're going to search out to get to this—to get the answers we need.

Mr. BACKHUS. That's always a difficult thing for us. I think there's other—the comment I made about the reliability of the VA data refers to the information that we have gotten thus far out of the reports to the Congress—the capacity reports. I think there are other sources in VA; a number of them that, when combined with this data, provide a better look. There are ways to take data—and differing data—ask questions and explain the differences. There are multiple sources of data that you can trace back to original documentation. That's the kind of process we go through. We'll take data from NEPEC and from PRAC and these other resource groups in VA, piece it together and eventually come up with something that seems to make the most sense.

So there's not one database in VA that you can go to but there are several sources within. In talking with people who run the programs there—dealing with the veterans on a day-to-day basis, you begin to be able to construct a picture. But it takes a lot of work. It's not a simple thing to do.

Mr. GUTIERREZ. Mr. Backhus, in your testimony, you state the VA's data and assertions thus far may—and I'll quote you "mask potential adverse effects on specific programs and locations." In conducting your research, have you found this occurring in certain localities? Can you share with us examples of adverse effects?

Mr. BACKHUS. No, I don't have any specific adverse effects. I really put the word potential in there to represent what it is we're going to be on the lookout for here. But at this time, I can't identify to you any particular instance of someone being adversely affected.

Mr. GUTIERREZ. Okay. Let me just quickly—to Mr. McCormick, I'm going to ask you the same question I asked Mr. Backhus. In your opinion, the VA maintaining its ability to provide services at the October 1996 level in specialized care?

Mr. McCORMICK. I can really only speak for the seriously mentally ill. I have to start off with a copy of our administrative databases which most of the report is based on are limited. They don't tell anywhere near the whole picture. It isn't even that the data is necessarily unreliable, it just isn't full and complete. I feel that the gauge that I would use looking at the total growth of VA and the direction of VA that special programs for the seriously mentally ill are not totally keeping up. That is, we are not—VA isn't maintaining its commensurate commitment that it had a year ago. Although the changes are relatively small, nationwide they are very large someplace.

Mr. GUTIERREZ. Mr. Miller, the same question. What do you think? Do they have the capacity, the VA, that they had in October 1996 to provide specialized services?

Mr. MILLER. I would kind of concur that it's somewhat mixed, but I would submit that, particularly in the area of prosthetics, their capacity has been significantly reduced. Staffing levels in the field and headquarters have been decimated severely impairing their ability to maintain capacity. Some of the other programs, if they are, it's very, very marginally. They're on the edge of the loss of ability to maintain capacity. But again, there's a lot of inconsistency from program-to-program across the system.

In response, if I might, to your earlier question to Mr. Backhus, data, one of the fundamental problems I think our committee has identified is inconsistency across the system as to how data is entered; how it is coded; how services are costed from one facility to another, from one network to another. If there are not national standards established and someone held accountable for those standards to be adhered to, we're not going to have good, solid data. They won't be able to roll-up national data because everybody's recording things differently—reporting in a different way, in a different format that just is not conducive to rolling up good, solid, accurate data.

Mr. GUTIERREZ. Thank you, Mr. Miller. Thank you, Mr. Chairman.

Mr. STEARNS. Mr. Bilirakis.

Mr. BILIRAKIS. Thank you, Mr. Chairman. Of course, the question offered by Mr. Gutierrez is the bottomline question and the reason for this hearing. We know that specialized services are the most expensive. So I guess common sense would dictate they might be considered the most vulnerable to cuts to the budgetary constraints. So that's why it's just so very necessary to be even more diligent than we are being. Tom, Mr. Miller, we got to know you real well.

Mr. MILLER. Now, I'm in trouble. (Laughter.)

Mr. BILIRAKIS. I've been here for 16 years—and I think you've probably been in that audience and testifying for at least that period of time—or close to it anyhow. Now, you're chairman of this advisory committee and I do want to commend the VA for its efforts in the creation of that committee. You gave us a history of it. Now you're an advisory committee of the VA—you're all volunteers, right?

Mr. MILLER. Yes, sir.

Mr. BILIRAKIS. You're an advisory committee of the VA. Have you been given the opportunity for input on this particular problem—specialized services—particularly prosthetics and, you know, the special disabilities?

Mr. MILLER. Yes, sir. Over the history of the committee—when ever we met, and we meet twice yearly usually in the March-April timeframe and then again in September of each fiscal year. Following each meeting, we submit detailed minutes of those meetings with a list of recommendation the committee wants to send forward to management. Normally throughout all of those meetings, we receive briefings from VHA management officials—

Mr. BILIRAKIS. I don't want to use up all my 5 minutes now—

Mr. MILLER. Oh, okay.

Mr. BILIRAKIS (continuing). On that, Tom. Forgive me for interrupting you, but I think I know you well enough that you'd be willing to do that. So you're not ignored. In other words, you do have inputs and do you feel that your inputs are creative and, you know, at least addressed and considered?

Mr. MILLER. In the last few years, we've had serious questions regarding whether or not they were read, and if so whether the responses have been less forthcoming in some situations. We've had some serious problems with the methods in which those reports were handled within VHA. We addressed those with Deputy Secretary Gober in our last meeting in March. He suggested some changes and we're hopeful that VHA will be more responsive in the future.

Mr. BILIRAKIS. All right now, so basically you've testified that there's been a drop in this maintaining of specialized services. That has happened since the Eligibility Reform Act of 1996. Is this any unintended consequence of that particular piece of legislation that maybe we should have taken into consideration? Any comments from any one of you in that regard?

Mr. MCCORMICK. Well, let me say I think that it was something to be concerned about when the VA attempts, as it is, to increase the number of users and to move to more outpatient delivery modes, the needs of special patients can be left behind. So I think the capacity section was a very well thought out portion. I guess my own view is that we need to continue to be vigilant. We need more data. It's very difficult to really make any final decision right now, but I think that it certainly was a good thing to highlight.

Mr. BILIRAKIS. Mr. Backhus, you have any opinion in that regard?

Mr. BACKHUS. Well, I think the incentives these days and in the field or divisions are to try to make the best out of limited resources, and to keep the cost of those patients down. When they're finding efficiencies, or ways to become more efficient, there is sometimes that tendency to seek out those patients who are less costly. It makes the special population somewhat vulnerable. There are protections that are in the system, such as this legislation to prevent that, and I think they are very important.

Mr. BILIRAKIS. But that protection is just basically a mandate, a rhetorical mandate, on our part. Isn't that true? I don't know when you say protection?

Mr. BACKHUS. That carries weight. I mean the legislation certainly does carry weight. I don't disagree with Mr. Miller at all. But from where I sit, there just isn't enough data yet to conclude that the capacity has been reduced. But there certainly is the need to find out.

Mr. BILIRAKIS. Yes, but the trouble is that by the time we get enough data, another year or so has gone by. That's much of the problem.

Mr. BACKHUS. Correct.

Mr. BILIRAKIS. You have a new Secretary of Veterans Affairs, I suppose coming aboard and I don't know, all sorts of different policies will change. But Tom, very quickly, I don't have more than a few seconds if you have anything to add to all that.

Mr. MILLER. Yes. I would indicate that I think the eligibility format was—has been a contributing factor and that it's increased the cost of prosthetic services, and increased workload for a number of these special programs. But I think even more importantly is the totally inadequate funding level for VA healthcare in general. To be fair to the network directors, facility directors, and the headquarters management, they have very, very difficult and a wide range of programs that they must fund and provide. There just aren't the sufficient resources for them to do everything they need to do and want to do.

Mr. BILIRAKIS. Thank you. Thank you so much. Thanks, Mr. Chairman.

Mr. STEARNS. Thank you, Ms. Brown.

Ms. BROWN. Thank you, Mr. Chairman. To Dr. McCormick—my question is—I guess it's nothing more disturbing to me, and probably most Americans, is that one-third of the homeless people are veterans. They're veterans with mental health problems or substance abuse problems. I think it's a direct relationship to us closing hospitals and putting them in the community and the services not following them to the community. In your testimony, you mentioned that we—you're serving more mental health veterans, but there have been a drop in serious mental ill, substance abuse and its treatment. Well, that's disturbing.

Mr. MCCORMICK. Certainly, as you accurately said, most homeless veterans that the VA treats—and there are estimates that there are as many as 200,000 to 250,000 homeless veterans. Most of them do have some mental disorder, including substance abuse that require care. VA's homeless programs actually have been among the best programs to get out into the community—use community resources, use residential resources in the community as well as the VA in an attempt to rehabilitate and take the homeless back to independent living. Again, this is a program I think that the Congress very much pushed and the Congress can be very proud of. And, overall, nationwide, it is still a program that is very viable and vital. My committee's main concern is that, of all the subclasses that had the largest decrease in any network, it was homeless that showed a 38 percent decrease in one network. So again, it perhaps highlights the variability issue more than any other portion of what we do.

Ms. BROWN. Well, following up—I note that you say that you have a drop in the amount of services that you're providing to these veterans.

Mr. McCORMICK. Well, again, nationally, you've got to remember that this particular report kind of breaks the homeless into two parts, like it breaks every population. The seriously mentally ill homeless versus the total population of homeless patients. The seriously mentally ill being those that are the lowest functioning of the homeless, if you will. Nationwide, there was not actually a decrease in the number of seriously mentally ill homeless treated. There was, however, the concern of the committee that there was really tremendous variations across networks; that the growth of the homeless that we actually served—and again, we only make a dent on that population—didn't grow at the same rate that our overall penetrance into the treatment of veterans in the Nation grew.

Ms. BROWN. Well, what would be some of your recommendations as to how can we have more aggressive outreach of forces to where it would be homeless veterans?

Mr. McCORMICK. Again, I think our homeless programs are, again, particularly vulnerable. Because the VA's healthcare system, much to its credit, goes much beyond the benefits that a private healthcare plan offers, you know. Services for homeless are more than just health services, they're also psycho-social and rehabilitation services to get them back into the community and producing revenue—actually producing dollars that can be taxed. Those programs need to be constantly highlighted and need to be constantly watched over. There needs to be vigilance to see that we don't lose our way to becoming a more narrow healthcare system that doesn't provide that broad range of benefits. The committee and myself were very happy to hear Dr. Kizer actually at a recent hearing talk about homeless being the fifth mission of the VA. We just need to make sure that that message filters down all the way to the levels where operational decisions are made in VA.

Ms. BROWN. Thank you. I have one other question. I have a little bit more time, I guess. Mr. Miller, do you think providing a performance measure in the Veterans Integrated Service Network performance contracts to address each of the protective specialization service would give Congress better assurances that the programs will receive adequate attention?

Mr. MILLER. Yes, I think that would be very helpful. I think accountability is crucial. I know I've heard Dr. Kizer and Dr. Garthwaite on many, many occasions in headquarters and their philosophy and what they expect. What we find in the field is often not consistent with their policy and how they conceptualize the system. I think if requirements were included in their performance standards making network directors and facility directors accountable would be very helpful in terms of monitoring, in placing the appropriate emphasis on these specialized services.

Ms. BROWN. Okay. Thank you, Mr. Chairman.

Mr. STEARNS. I thank my colleague. Are there any additional questions?

I want to thank the panel very much for their time and efforts. We will now have the second panel.

Dr. Thomas Garthwaite, Deputy Under Secretary for Health, Department of Veterans Affairs; Dr. Fitzgerald, Director of VISN 1; and Dr. Leroy Gross, VISN 6.

We want to welcome you folks this morning and appreciate your taking time in your busy schedule to come by and talk to us. Why don't we start with Dr. Garthwaite? Doctor, you have an opening statement.

**STATEMENT OF THOMAS GARTHWAITE, DEPUTY UNDER SECRETARY FOR HEALTH, DEPARTMENT OF VETERANS AFFAIRS; ACCOMPANIED BY DENIS J. FITZGERALD, DIRECTOR, VISN 1, AND LEROY GROSS, DIRECTOR, VISN 6**

**STATEMENT OF THOMAS GARTHWAITE**

Dr. GARTHWAITE. Thank you. Mr. Chairman, I'm pleased to be here to reaffirm VHA's commitment to maintain and where feasible, enhance the scope and quality of our specialized treatment and rehabilitation of disabled veterans. VHA's programs that meet the specialized needs of veterans help define the VA as a unique healthcare system. VA has developed strong expertise in specialized services for veterans with spinal cord dysfunction, blindness, traumatic brain injury, amputation, serious mental illness, and post-traumatic stress disorder. These services are not widely available in the private sector and we are committed to meeting the needs of veterans who rely on VA for these specialized services.

Public Law 104-262 requires that we maintain capacity to provide for the specialized treatment and rehabilitative needs of disabled veterans. The legislation requires ongoing monitoring of the capacity of these special programs. We have submitted two reports to Congress—one in May 1997 and one in June 1998—detailing our efforts to measure capacity. In the process, we have consulted extensively with and will continue to work with service organizations, advisory committees and others in implementing monitors of the performance of these specialized programs.

While we have developed various working definitions for terms identified in the law, we appreciate the complexities and the realities underlying the concepts of capacity and access. We seek practical solutions for measuring these today as we work collaboratively to find enhanced measures for the future.

Our June 1998 report reflects that nationally the numbers of veterans treated in the six programs was maintained or increased for all categories, except amputation which declined by 2 percent. We do believe that the decline in amputations was due to greater emphasis on preserving limbs and better management of veterans at risk for amputation. My formal statement discusses our performance reached in specialized programs as reported in our June report.

Several issues have been raised about the data presented in or underlying our report. We are, and we will continue to be completely open with our data and our methods of analysis. We welcome questions from and discussion with all interested parties. We look forward to providing this committee with specific responses to data concerns raised during this hearing and at any time in the future. While we believe that our data systems have many strengths,

we also believe that we have much work to do to accomplish their continued evolution. In addition to the myriad of data enhancements currently underway, we will have a data summit later this year and will seek broad participation from those outside VA who depend on our data to track quality and system improvements.

We continue to listen and communicate with our VSO colleagues and we continue to ask critical questions of ourselves regarding how we might enhance, not just preserve these outstanding programs. Recently, Drs. Kizer, Holahan, and I spent 2 hours with PVA's top leadership discussing their concerns. We continue to work on various issues raised during that and other meetings. I think PVA and VHA are making good progress in developing outcome measures for patients with spinal cord dysfunction. An effort which will once again have that partnership leading the way in the advancement of care in spinal cord disease.

In mental health, we have examples of outstanding leadership and creativity in network service lines. As we learn from those leaders, we will aggressively teach the best practices for others to follow. We believe that other initiatives such as our mental health report card, the recently funded mental health research and education centers, the recent funding of our quality enhancement research initiatives in mental health, and expanded funding of our homeless grant and per diem program, voted by VISN Directors for inclusion in our budget, reflect our commitment to these patients. Early detection of illness, outreach to enroll patients, and coordination of care are fundamental issues which underlie all we've been doing to reinvent the Veterans' Health Administration—these issues are especially important in mental health and in special programs.

In blind rehabilitation, we are proud of our service and our history, but we are not content. We are chartering a gold ribbon panel, in honor of the 50th anniversary of the blind rehabilitation service, to help us visualize the best integration of blind rehab with our decentralized network structure and to suggest ways that we might effectively serve additional visually-impaired veterans.

In prosthetics, we are concerned that an increase in workload has resulted in gradual increase in delayed orders. We are aware of problems and have taken specific actions to address them, including staffing adjustments, central earmarking of funding, and continued careful monitoring of delays. Dr. Kizer has charged our prosthetics and sensory aids service to develop additional performance measures that will address quality, access and satisfaction in prosthetics in addition to the historical tracking of timeliness.

In conclusion, I'm pleased to report that VHA has maintained its national capacity to provide for the treatment and rehabilitation of the broad groupings of specially disabled veterans. While some subgroup and some network variation exists, we continue to monitor and work to understand these variations and take action to assure these patients are not adversely impacted by the needed changes in the Veterans' Health Administration.

The veterans we are discussing here today, to a great degree, are the reason there is a VA health system. We've made many changes in the VA in the past 3 years. Change is not easy. It has been said that people don't resist change, they resist change for which they

see no reason. Our reasons for change are clear—better service, better access, better quality, and better outcome. We thank you for the opportunity to discuss these issues and look forward to your questions.

Mr. STEARNS. Thank you, Dr. Fitzgerald.

[The prepared statement of Dr. Garthwaite, with attachment, appears on p. 78.]

#### STATEMENT OF DENIS FITZGERALD, M.D.

Dr. FITZGERALD. Thank you very much. Mr. Chairman and members of the committee, I appreciate the opportunity to appear before you today to discuss the management of and support for our special programs. VISN 1, VA New England Healthcare System includes nine medical centers located in the sixth New England State. We provide the full spectrum of healthcare services, including most special programs.

The importance of the special programs has been recognized in VISN 1 and appropriate support has been shown throughout the network. Our strategic plan is linked to our financial and human resource plans to ensure that these programs will receive appropriate attention and the necessary resources to operate effectively now and in the future. The patient focus inherent in the implementation of service lines will further enhance the quality and assessibility of these special programs. Network 1 Westhaven has maintained capacity to provide veterans a full-range of blind rehabilitation services. A 100 percent of veterans referred to inpatient blind rehabilitation have access to the program within 6 months of their application.

The SCI program capacity at Brockton, West Roxbury is more than adequate to meet the current and anticipated demand. The number of patients treated has remained about the same during the past 2 years and the total dollars allocated to the SCI program has increased. Access to care is excellent and performance on national customer service standards placed the Brockton, West Roxbury SCI program number 1 among all VA SCI centers in the areas of access, information, emotional support, overall coordination of care, and continuity of care.

VISN 1 provides a comprehensive list of inpatient and outpatient services for the mentally ill veteran. Seventy-six percent of our veterans are seen within 30 days of discharge compared with the national average of 68 percent. According to a report card furnished by the Northeastern Program Evaluation Center, Network 1 was ranked 7th over all the mental health services. VISN 1 was a pioneer in developing intensive psychiatric community care programs and support 2 of 9 programs for the treatment of veterans with comorbidities of PTSD and substance abuse. Facilities in our network have been home to many national mental health programs—two of the three national schizophrenia centers; four of the six divisions of the National Center for PTSD, and national mental illness research education and clinical center—to name a few.

I am very proud of the efforts of the employees of VISN 1 to continue to improve the excellent service they provide to the veterans of New England. We have come a long way, but much more needs to be done. I have the privilege to work with staff who are dedi-

cated to providing the best care possible to all our patients. The close ties we have with many excellent medical schools and universities enhance the care we offer, as well as the education and research opportunities available to our staff. These four special programs are of prime importance in carrying out our assigned mission. They will continue to receive appropriate attention and the support of Network 1.

Thank you for inviting me to speak before you today. I appreciate you support for our efforts to provide the best possible care to our Nation's veterans. I would be please to answer any questions you might have.

Mr. STEARNS. Thank you. Dr. Gross.

[The prepared statement of Dr. Fitzgerald appears on p. 85.]

#### STATEMENT OF LEROY P. GROSS

Dr. GROSS. Mr. Chairman and members of the committee, I'm privileged to testify about the implementation and management of specialized treatment and rehabilitative needs for veterans that are disabled and Veterans Integrated Service Network 6.

VISN 6, or the Mid-Atlantic Network is comprised of eight healthcare facilities and other VA medical programs in Virginia, North Carolina, and Beckley, West Virginia. We have strong academic affiliations with six major universities and other teaching facilities. We serve a growing veteran population in this area that has increased over the past 2 years. A good percentage of these veterans do require the support of our specialized programs. The leadership of VISN 6 has recognized early on the need to give priority to specialized programs in this era of declining resources. We're now in the third year of refining our structures, processes and outcomes to maintain and even expand the capacity to meet our commitments to disabled veterans.

The hallmark of our structural changes is characterized by the formation of multi-disciplinary teams that are patient-focused and that place authority and responsibility and accountability at the lowest level where care is provided. This concept is known as service-line management. VISN 6 has established service-line for spinal cord injury, mental health, primary care preventive health, and geriatrics and extended care. SCI, mental health and primary care will have independent budgets in 1999—this coming fiscal year—and this will enable VISN to improve the monitoring of our resources to more accurately reflect our outcomes to increase access and even to positively affect patient satisfaction.

I would like to comment on a selected specialized programs as follows and the blind rehabilitation program. VISN 6 continues to support our VIST or Visual Impairment Service Team coordinators at each medical center. In March 1997, a network coordinator was appointed to insure consistency in programs for the visually impaired veteran population throughout the VISN. We refer our visually impaired patients to West Haven, CT and Augusta, GA for residential rehabilitation support. We estimate that the population of the legally blind veterans in VISN 6 is anticipated to increase by 122 percent by the year 2005.

In the area of prosthetics, VISN 6 has redirected a portion of its workforce between 1996 and 1998 to generate a 9 percent increase

in personnel to support our prosthetics programs. Our delayed orders for VISN 6 continues to be below the benchmark of 2 percent threshold for fiscal year 1998, notwithstanding the fact that we have increased our workload 19.8 percent over the same period.

In providing care for veterans with amputations, our preservation and amputation clinic and treatment programs are operational at each facility. The amputation workload in this network is projected to decrease which is according to the national trend.

In mental health, from April 1997 to March 1998, mental health patients treated in our outpatient programs increased by 13.4 percent over the number in 1996. For this same period, inpatient episodes of care decreased by 17.4 percent. We at VISN 6 have a broad menu of health services at each facility in mental health. These are augmented by specialized programs at selected medical centers.

As noted previously, spinal cord injury and disease is one of our service lines. This program provides 164 beds for our inpatient, acute, and long-term care spinal cord patients. These centers are located in Richmond and Hampton. Our centers also support three contiguous VISNs. The remainder of our facilities—the other six—have qualified as the primary care teams that have been formed and trained to provide ambulatory support services for veterans closer to their homes. We've noted in VISN 6 that there's been a 10 percent increase in our patient workload since 1996 for SCI.

At this time, I would like to take the opportunity to thank members of the PVA, DAV, and VFW American Legion and other VSO's for their input and participation on our Management Assistance Council, or MAC, and my planning boards. I rely heavily on stakeholders that the VSOs provide me the input I need to help in managing specialized programs. Although we may not always agree, their input and assistance as I indicated is invaluable in the change process.

I would like to pay special tribute to PVA members, Mr. John Malone, who was our VISN 6 PVA liaison officer; and Mr. John Devine, and Randy Pleva in West Virginia for their outstanding support to the MAC. I cite them because their progressive disease processes have lately not allowed them to continue to support us in the recent months. While they were there, they were very, very helpful.

Mr. Chairman and members of the committee, I want to assure you that VISN 6 will continue our efforts to fully comply with the spirit and intent of section 1706, title 38, USC. Treating more veterans with specialized needs over the past years, I think in my network has demonstrated the ability to maintain the scope and availability of these programs even while expanding them.

I thank you for your support and I remain available to answer your questions.

[The prepared statement of Dr. Gross appears on p. 94.]

Mr. STEARNS. Thank you, Dr. Gross.

I guess I might start out with you, Dr. Garthwaite. You've heard the criticism from two expert panels before. Would you acknowledge this morning that there's more than just a problem? Differing perceptions here? Do you think there is a problem, or how would you characterize a problem? Perhaps do you have any solutions?

What is your reaction here? Mr. Thomas Miller, you've heard his comments. I'm just curious what's your perception of this?

Dr. GARTHWAITE. I think there have been tremendous changes made in the VA. Many of them are positive. I also think there are, always have been, and always will continue to be issues that we will need to address. When you try to deal with a system that has 173 hospitals and when you try to operate a hospital system that has hospitals in every area of the country, there will continue to be variation and some immediate areas of concern. I've not had time to review the PVA's concerns, but they have some specific concerns at specific medical centers and I'm very anxious to find out more about them.

But I think, overall, if you ask the question, have we seen the same number, total number of veterans in these categories across the VA system, I think we can answer yes. If you ask the question is there variability in healthcare across the United States and in specialized programs—my answer is yes, there is. Dr. Wennberg, at Dartmouth, has shown—in the Medicare population—dramatic differences in healthcare in the private sector. Do we notice differences in healthcare and therefore differences in all parts of our healthcare across the VA system? Yes, we do and we're trying very hard to understand whether those differences are related to funding, to staffing, to local variation and employee availability or to policies or things that we can affect nationally.

Mr. STEARNS. Well, I understand your answer. I understand it's a little bit circumspect. But we've heard from experts here that say it's a problem; there is a definite problem. Yet, I hear from you, you don't know if there's a problem yet. You need to look at it further. You're saying that from VISN to VISN, it can explain the problem. Do you think there's a problem? Just yes or no. I mean, it just seems like if I were in your position, I would—

Dr. GARTHWAITE. Well, I would think there's a problem.

Mr. STEARNS. Yes, I would say that you're telling me that you just think it can be explained by just saying from VISN to VISN, the predictability, and probability and things like that. I think we've heard from experts—got a GAO audit that's starting. The question is for you, is there a problem or not?

Dr. GARTHWAITE. I hesitate to give you a simple yes or no.

Mr. STEARNS. Well, obviously, then you don't think there's a problem?

Dr. GARTHWAITE. No, no I don't. I think there are multiple problems at multiple levels.

Mr. STEARNS. So, there's a problem?

Dr. GARTHWAITE. There's certainly a problem that veterans' service organizations have perceptions of loss of capacity. There are specific local issues, as I said in all healthcare systems that will have specific local issues and we can call those problems. So there are specific local problems. Are they different because there's legislation? Are they different in relation to what they were before we started all the change or are they better compared to what they were before we started all the change?

Mr. STEARNS. Do you think the problem—

Dr. GARTHWAITE. I think it's hard to answer that with a simple yes/no.

Mr. STEARNS. Do you think the problems are more a function of management or lack of money? Either one. I mean can't you just give an answer to that? Or both—there's a third answer.

Dr. GARTHWAITE. I think there are some management problems that we attempt to deal with. I think we can give you examples of where we've done that specifically. I think there are, have been, continue to be, and will always be a tension on our ability to meet all the demand. So we will always have the tension and we will try to give as much quality care with the dollars that we're given. So we're always fighting that tension of treating additional veterans, who would not get care if not for VA, and treating as many patients as we can without wasting any dollars. So there's always that tension.

Mr. STEARNS. Part of my question is, obviously if you don't think there's a problem, you're not going to do anything. But if you think there's a problem, then the question is what do you propose to do to solve it? I really haven't felt that you think there's a problem and that you are really clearly going to map out a program to solve it with alacrity. That's just what's coming across to me. Now, I don't know if you want to correct that impression or not.

Dr. GARTHWAITE. No, I think in my oral testimony I hit on several specific issues that I think we will do to try to address some of the concerns that have been raised in other testimony.

Mr. STEARNS. Okay. Dr. Fitzgerald, your VISN I understand is up in Boston, the New England area?

Dr. FITZGERALD. Yes, sir.

Mr. STEARNS. VA's capacity report indicates that in your VISN the number of patients seen for serious mental illnesses, substance abuse, and PTSD are all declining substantially. Now, I just heard that the demand in this area is increasing. How do you explain that? In the area of mental health, the VA's capacity reports shows that your VISN workload actually is declining substantially—not just, incrementally. A substantial decline. How do you explain that? What specific plan for providing mental health services do you have? How do you explain the statistics?

Dr. FITZGERALD. With the chronic mentally ill volume that we're seeing, I would look at those statistics very carefully. I believe that in the area of substance abuse, for the first two quarters of 1998, there was a decrease in the number of patients seen in the ambulatory environment. But other than that, I'm not aware of a significant decrease in the area of chronic mental illness.

What we have devised in VISN 1 to handle the mentally ill services—we've developed a VISN-wide council on mental health. We have developed special programs and actually have an over-capacity in terms of inpatient beds versus the rest of the Nation. We have over 550 beds in mental illness; some 235 of them are for chronic mental illness. We have in addition to that, 111 beds in outpatient PTSD rehabilitation and residential care for the homeless veterans who are, as you know, in large part have dual diagnosis. Our team is leading the way in how we deliver mental health services across the VISN. So I think that our capacity has been maintained according to the information except in the area of substance abuse. We are looking into that as to the reason to first of all validate whether that reason is true. Second of all to look at

the root causes of that difference and we will be moving to correct that as appropriate.

Mr. STEARNS. Dr. Garthwaite, you heard earlier in the first panel when we asked them about the management practices and the data from VISN to VISN. It was implied that the regional inconsistencies between the VISNs dealing with the special disability programs exist. How do you react to that concern that we have now had experts saying that from VISN to VISN the consistency is not there. Are you concerned about that? How do you reconcile this inconsistency with a system whose funding is based upon the principle of equity of access?

Dr. GARTHWAITE. I think we're very much concerned with any inconsistency that's unexplainable. We're interested in the explanations and whether they're reasonable or not. So the answer is yes, we're very concerned. We're looking at variability in many programs across networks moving from a single system to a network system, which has allowed us the opportunity to explore those differences and care patterns. We're pleased to work with people in our mental health programs and with our committees to explore why those exist and what significance they might have.

Mr. STEARNS. Dr. Gross, anything you might want to add to some of the questions I've asked?

Dr. GROSS. Yes, sir. I think as an individual in the field with perspectives as a manager of this healthcare system in Virginia, North Carolina, and West Virginia, I have a need for data. I find that the decisions I need to make and that the service line managers need for their specialized programs—are better databases. So I certainly will be working as best I can to support that. Because as I reviewed the written testimony of the organizations before I arrived—the GAO, PVA, et cetera, there's a wide variability in the numbers for the same issue. My numbers are different from theirs. So that's one problem that I think I need resolved.

The other, as I look at the capacity issue, in my network—and I'll use spinal cord as an example. As long as I can see all the patients that want to receive spinal cord services in my network, I feel that I've maintained the capacity. In my network, to the best of my knowledge, that is true. It is not equated to the number of beds, or the staff, or the dollars which is something that, it appears, is the measurement of capacity. So I would hope that we would take a look at access and quality. Because quality is there, the access is there in my network, and cost of course we have to monitor.

Mr. STEARNS. Thank you. Mr. Bilirakis.

Mr. BILIRAKIS. Thank you very much, Mr. Chairman. Dr. Garthwaite, I'm going to take a few seconds just as a reminder and then I'll go maybe into some questions, but not in connection with this reminder, if you will. You're smiling, so you probably have a pretty good idea of what I'm going to say.

Several months ago, you sat in on a meeting that I had with Deputy Secretary Gober.

Dr. GARTHWAITE. Correct.

Mr. BILIRAKIS. To discuss the Tampa SCI construction project. At that meeting, Secretary Gober—and if you disagree with this comment, you certainly can tell me so—but at that meeting, Secretary

Gober gave me his personal assurances that the Department would include funding for the SCI center in its Fiscal Year 2000 budget. Now I know that the Department is in the process of compiling this budget; I'm just reminding you.

All right, let me ask you, sir. You're not under oath. You're an honorable man. I know this committee has had a lot to do with you and I don't think any of us have any ill feelings towards you or any of your good people. I've always thought frankly that veterans healthcare services are a pretty darn good services. Sure there are problems there. God knows in every hospital in the land there are. This is not to excuse now some of these things that we've talked about, not trying to whitewash us. But can you tell this committee that, as far as you know, even though the specialized services are the most expensive and even though they are the most vulnerable to cuts to the budgetary constraints, that there has not been any directive from on high or any directive from any of the directors of the VISNs to basically curtail, or to cut any of those as a result of the fact that they are much more expensive.

Dr. GARTHWAITE. To the contrary, it was clearly the message from on high, if you will, doesn't feel that way most days. But from headquarters, it is very clear that we're not to diminish our capacity to treat veterans. In preparing for this testimony, I reviewed that with the two network directors that are sitting here who can remember their first day on the job hearing that from Secretary Brown. It's been a consistent message that we've put forward.

Mr. BILIRAKIS. Well, but things apparently have happened. We've had testimony here. Some of the veterans' service organizations will be testifying. PVA has conducted their own surveys, and we can get into that if we have time. So, you know, there has been apparently an impression at least, if not anything else, of the curtailing of those services and not having lived up to the directive in the 1996 Act. Of course, we don't have the centralization to the point that we had previously. Isn't that correct? Could that be a problem?

Dr. GARTHWAITE. Yes, certainly the changes with decentralization could be a problem. But I think if you look overall at patient satisfaction, survival, morbidity, mortality, and surgery, the number of patients treated, preventive health measures, and so forth. Most measure are on a good trend. What we have to do is dissect out whether there have been specific instances and specific specialty programs where we failed to meet our expectations.

Mr. BILIRAKIS. You indicated—I think it was you during your testimony—that you have sat down with PVA and spent an awful lot of time with that particular organization.

Dr. GARTHWAITE. All of them.

Mr. BILIRAKIS. All right, but the veterans groups have told us—and they'll testify to this—that they've taken their own counts. Those counts do not square with basically the data that's been furnished by the VA. Have you discussed that in your conversations with the PVA?

Dr. GARTHWAITE. We've had some discussions. We clearly need to have more discussions about the specific data issues. Because data is very definitional. There's a lot of difference between an operating bed and a staffed bed. We staff based on current demand. It's a very complex and hard-to-do process. I would say that's where we

fail, that's often a place we fail. I think that's true in every hospital I've ever worked in. As they're getting the right staff for the right number of patients on any given day is a very difficult process. Because people don't sick on cue and there are a lot of other factors about our employees that relate to that. So I would just say that staffing is exceptionally challenging in any medical facility having—

Mr. BILIRAKIS. I complimented the chairman for calling this hearing initially because there are perceived problems out there. Perception sometimes can be even stronger than fact. I frankly think there are probably some factual problems out there. I think you all would admit that.

Dr. GARTHWAITE. I'd agree to that.

Mr. BILIRAKIS. PVA has recommended that the maintenance of capacity for our specialized services be made a part of performance measures for management personnel—from the level of the VISN Director on down. Do you agree with them?

Dr. GARTHWAITE. We're working on trying to get valid measures that we can use for that purpose. We'd like to put together an index similar to our prevention index for chronic care and disease that reflects our overall performance in those areas.

Mr. BILIRAKIS. In those areas—so you do agree with them?

Dr. GARTHWAITE. Correct. Yes, not a problem.

Mr. BILIRAKIS. Have you implemented any safeguards to ensure that specialized services are maintained since the 1996 Act? We don't have decentralization anymore and you're talking about more expensive services here. Human nature might dictate that a Director might say "Hey, I'll borrow a little bit from here in order to take care of this." Knowing all that, have you implemented any safeguards to keep that from happening?

Dr. GARTHWAITE. Yes, I believe we have. We certainly made it high priority to the network directors. They can testify as to our consistent admonishments to them at various meetings. In addition, we've continued to maintain centralized control of prosthetics funding simply because we don't believe that we have adequate tracking mechanisms yet. When we get those we might reconsider that, but we think that's a key piece. We've put a lot of money into the monitoring of mental health programs. We have like 80 FTE in the NEPEC (northeast evaluation program evaluation center). We have, as I mentioned in my oral testimony, moved forward to understand the quality of care we're giving in mental health. Our quality enhancement research initiative which is a major new initiative to put data behind these decisions and to make sure we can assure you, our patients and veterans' service organizations that we're giving the best care possible. I'm sure there are more that I can give you for the record.

Mr. BILIRAKIS. Well, all right, Mr. Chairman, my time is up. I guess, you know, I get concerned we talk about data. Only 25 percent of the investigation by the GAO has been completed. It seems like we can do better than just—not that the data is not significant, Dr. Gross, you're right, but it seems like we could really do a heck of a lot better than just depend on data and that sort of thing.

Dr. GROSS. Talk to the veterans.

Mr. BILIRAKIS. I think that's basically—

Mr. STEARNS. Mr. Miller.

Mr. BILIRAKIS. Thank you, sir.

Mr. STEARNS. Yes. Ms. Brown.

Ms. BROWN. Yes, before I get into my couple of questions. Will someone just take a minute—one of the three—and explain to me the Veterans Integrated Service Networks. Just explain to me how that's working.

Dr. GROSS. Yes, ma'am. Veterans Integrated Service Networks—there are 22 of these. They are regionally based and were established according to the patient referral patterns. In my network, like I said, I have Virginia, North Carolina, and Beckley, West Virginia. So these are essentially regions that have been carved up and the authority and responsibility has been decentralized to the directors of these respective networks or VISNs.

Dr. GARTHWAITE. I'd just add one amplification of that from a central perspective. That is, that we used to be hospitals that competed with each other for funding and services and so forth. The goal has been to think of ourselves, not as a collection of hospitals, but as entities that are responsible for a population of people and their overall care. I think it's had a profoundly positive effect on the coordination of care within a geographic area.

Ms. BROWN. Yes, and my understanding, yes, you do have 22 and only 1 African-American.

Dr. Gross, nice meeting you.

Dr. GROSS. Two.

Ms. BROWN. Two?

Dr. GARTHWAITE. We recently hired a Mr. Danridge, yes.

Ms. BROWN. Yes. You have two now?

Dr. GARTHWAITE. Yes, correct.

Ms. BROWN. How many women?

Dr. GROSS. I think there's six.

Dr. GARTHWAITE. Let me count them out.

Ms. BROWN. [Laughter.] Okay.

Dr. FITZGERALD. I think we have four.

Dr. GARTHWAITE. More than that, I think. I'll have it in a minute.

Ms. BROWN. Well, we're working on the problem. (Laughter.)

Let me go to my question. VA has a variety of performance measures that's supposed to ensure that these network directors make certain things happen for the VA. Directors are rewarded for recruiting new veterans, patients, for shifting care from inpatient to outpatient settings, and for saving money. How can we ensure that these programs are working for the veterans and that we have high standards? Is there something in the performance contracts to this effect? If not, how can we put it in the contract to these different providers?

Dr. GROSS. Yes, as part of the establishment of the networks, we started initially—and have even expanded what we call performance measures. There are like 24 of these measures. They are very numerous. We have quarterly report cards, if you will, of how well we're doing. Some of these are stretch goals. Some are very difficult to attain. It spans the spectrum from MCCF or collecting money from third-party billers to ensuring that we have clinical practice

guidelines, et cetera. So they're broad in scope and they're reviewed annually. So we're held accountable for that. So my report card, my assessment, is based on how well I do. There are other measures that Dr. Garthwaite also even adds as objectives. Now, these are objective measures, but there's some subjective components that he may be able to address.

Dr. GARTHWAITE. Yes. I would just add that initially what data was available to push performance and what some of the major issues facing VA were related, in part, to structure and to providing care for inpatient versus outpatient. We're evolving away from those measures and evolving to outcome measures for patient's health. I think that's really the essence of your question. We want everyone in the whole system to be focused on improving outcomes for patients. So that's really the goal the performance measures.

Ms. BROWN. My next question pertains to VA is going through downsizing of the institutions. You know, we had that in this country in the 1970's and 1980's. The homeless, in my opinion, is the result of it. What kind of assurances do we have that VA, as they go through this, are not going to repeat those same mistakes? Dr. Fitzgerald?

Dr. FITZGERALD. We have initiated, nationally, four pilot studies, one of which is in New England. Essentially, what it is is a homeless program where the VA and its resources reach out to the community and its resources so that we avoid duplication. We come together in a cooperative manner across the entire network. This has resulted in a 15 percent increase in the identification of homeless veterans within New England in the short 12-to-15-month period that this has been in operation. We're continuing this with the appointment, not only of a network coordinator of the homeless program, but also local coordinators at each one of the facilities. Homelessness is as different in Maine as it is in Boston. I mean, it's a very, very different problem depending upon the different areas. It requires a local approach, using local community resources. That's what we're attempting to do. So far in the 12 to 15 months, it's been working. It's been very successful.

Ms. BROWN. Thank you. Thank you, Mr. Chairman.

Mr. STEARNS. I thank the gentlelady. Dr. Cooksey?

#### OPENING STATEMENT OF HON. JOHN COOKSEY

Mr. COOKSEY. Well, it's good to see you again, Dr. Garthwaite, Dr. Fitzgerald, and Dr. Gross. I'm always glad to have physicians here. I'm encouraged and feel very good to know that there are areas of expertise that the veterans' hospitals have that other hospitals don't have, particularly in spinal cord injuries. It's obvious that the reason that you do have that expertise. I think there's some other areas. We have a VA hospital in my district that is really a well-run hospital. I would make an overall comment.

I think this patient protection legislation that is on the front burner—on everybody's mind now—is there's some need for a lot of it is politics driven by the election coming up in November, and does not really address the overall problems, but that we're working on them. But we really need to be thinking in terms of moving to a system where we can go to areas that, where there's the top expertise on spinal cord injuries, for example, and put enormous re-

sources in there. If it's in the VA hospital, that's where it should go. I, personally, have a heavy bias toward veterans, being a veteran. I feel that veterans that have war injuries, or training injuries, should have unlimited resources for their injuries and long-term care. But there is some duplication in this country, not so much in the veterans' hospitals, but in a lot of other hospitals and probably to some extent there. But we still need to think in terms of an overall restructuring. I want the veterans' hospitals to be big players in this. I want the veterans to benefit from some restructuring. We ultimately need to move to a more of a system that is a market-driven system for the non-Medicare patients. Then we won't be worried about patient protection. But always on the front burner for me will be the veterans that have some injury that they got in combat.

I, quite frankly, am not as sympathetic. We, in my congressional office, 35 percent of our constituent services is for veterans, and 35 percent is for social security. All of which are related to disability. I just feel that there are too many people that are looking for disability that did not get their disability as a result of a war injury. They got it as a result of falling off the back of a pickup truck at Fort Pope in Louisiana. It bothers me when I see people that really got war injuries that don't get what I think are adequate resources. So I really think we need to start thinking in those terms. You do a good job and I want to assure you that you will have support from those of us on this committee, and me on this committee. But we still need to look at the big picture. Thank you.

Dr. GARTHWAITE. Thank you, Mr. Chairman.

Mr. STEARNS. We'll take the next panel. I thank you folks for coming here. I know how busy you are, too. I appreciate your time very much.

Panel three is Mr. Gordon Mansfield, Executive Director of Paralyzed Veterans of America; Mr. Thomas Miller, again, Executive Director of Blinded Veterans Association; Ms. Jacqueline Garrick, Deputy Director, National Veterans Affairs and Rehabilitation of the American Legion; Mr. Richard A. Wannemacher, Jr., Association National Legislative Director, Disabled American Veterans; and Mr. William Warfield, Deputy Director of Government Relations, Vietnam Veterans of America. It's a honor for the subcommittee to have you here this morning. Appreciate your taking the time. We look forward to hearing your testimony. We'll start with Mr. Gordon Mansfield, Executive Director of Paralyzed Veterans of America.

**STATEMENTS OF GORDON MANSFIELD, EXECUTIVE DIRECTOR, PARALYZED VETERANS OF AMERICA; THOMAS H. MILLER, AGAIN, EXECUTIVE DIRECTOR, BLINDED VETERANS ASSOCIATION; JACQUELINE GARRICK, DEPUTY DIRECTOR, NATIONAL VETERANS AFFAIRS AND REHABILITATION, THE AMERICAN LEGION; RICHARD A. WANNEMACHER, JR., ASSOCIATE NATIONAL LEGISLATIVE DIRECTOR, DISABLED AMERICAN VETERANS; AND WILLIAM WARFIELD, DEPUTY DIRECTOR OF GOVERNMENT RELATIONS, VIETNAM VETERANS OF AMERICA**

**STATEMENT OF GORDON MANSFIELD**

Mr. MANSFIELD. Thank you, Mr. Chairman. We're still getting arranged down here.

Mr. STEARNS. That's okay. Take your time.

Mr. MANSFIELD. Mr. Chairman, first of all, I'd like to introduce myself. I am Gordon Mansfield, Executive Director of Paralyzed Veterans of America. I'd like to request that my full statement be submitted for the record.

Mr. STEARNS. Without objection, so ordered.

Mr. MANSFIELD. In light of what we've heard here, I'd like to make some selected comments based on the testimony that's been presented.

First of all, I want to say that the people involved here from the Department of Veterans Affairs—Dr. Garthwaite; VISN Directors—Dr. Gross and Dr. Fitzgerald; and Dr. Margaret Hammond who's in charge of SCI; other VISN Directors, and others in this system are good people. They're caring people. I think they want to work to take care of veterans. But what's been going on here is a health care system where we've had massive change. In the process of that change, I believe that what we're seeing is that the management of the VA is attempting to track the civilian managed care HMO models. In my mind that means that they are looking at dollars, dollars, dollars, and dollars. They ought to be looking at patients, patients, patients. They ought to be looking at veterans, veterans, veterans.

We're in a situation now where the last time I heard Dr. Kizer speak, he indicated that 25,000 beds are gone—closed, out of the system. In addition to that, we have limited resources. The congressional appropriation has been set at a certain level. I'll just slip by a reminder that we recently had a deal with some highway robbery down here where veterans benefits were cut to pay for road construction. Next there are management issues. We now have a situation where we have 22 VISN Directors. To some degree I think we've got a situation with the decentralization of the system, that those 22 separate VISN Directors believe that they can do whatever they want to do in their own VISN. This is a concern for spinal cord injury programs because we view, as I believe the doctor indicated, spinal cord injury in the VA as the only national spinal cord injury care program. Also it's the only care program that covers care from onset of injury all the way through long-term care. It's the only national program that does that.

We're concerned also as it's been indicated here by both the VA and the GAO, about the VA's ability to count, to know what its ca-

capacity is. I will tell you that the SCI system has been in the VA for more than 30 years. There are 22 centers. Patients are supposed to be kept track of at these centers. PVA put at least \$.5 million of our own funds into implementing an SCI Registry of Patients. But apart from our efforts I bet the VA would not be able to tell you how many SCI patients they have.

Another area of concern deals with what's going on with decentralization and with the changeover to an area that Mr. Bilirakis referred to, construction.

There are two things going on there. One is construction that's now being handled at the local level under minor construction rules, regulations. We find the VA is going forward without any compliance with accessibility regulations or other requirements of construction law. In addition to that, as indicated in Mr. Bilirakis' concern about the new Tampa SCI Center, which PVA shares and has shared for 18 years, there's a lack of construction of new SCI facilities. This leads you to wonder where the future of the system is going to be if they're not going to take care of the needs that have been expressed and as the member presented.

Then we come to what, I believe and PVA believes, is the biggest concern that we have, which is staffing. In all this change—and getting rid of 25,000 beds and other changes going on—we find that the biggest problem we have in the SCI centers, and in other places that are taking care of SCI patients—SCI or special cord dysfunction—is staffing. It's one of these cat chasing its tail deals. Because if you ask the VA what the problem is, they'll tell you the reason staffing is down is because patients are down. We do not believe that is true. The reason staffing is down is because they don't have the resources. People are paying attention to the dollars rather than the needed care. They're making decisions based on dollars and resource allocation, rather than the patient needs.

When you get into a situation where, as we've indicated in our testimony, you have 80 beds but you can only staff 60 of them, then the medical professionals have got to make a decision ethically that they won't put the next person in that bed. So it's a staffing question related to resources.

Then I think you folks here in Congress have got a problem. Because if you pass a law for VA to maintain its specialized services capacity, I think you ought to expect that it would be followed. We're saying that the law and capacity have not been followed and maintained. Examples of our concern include vets being moved out to community nursing homes and then coming back with pressure sores. We're saying that's something new that's happened in the last few years across the system.

We're seeing vets not being transferred to SCI centers from other VAMCs because the people at that other VAMC want to keep the dollars with that patient there. We're also seeing patients not being treated responsibly in a medical sense because of the lack of staffing—people not being bathed; people missing meals; people missing appointments; people not being taken care of the way they should.

The solutions, we believe, are to provide the dollars as needed. We think that we need a centralized management responsibility for national programs. We think the VA needs to get accurate data. We have to understand, again, that the reason we have a VA is to

take care of the specialized needs of veteran patients. I see the red light, Mr. Chairman, and I'll await further questions.

Mr. STEARNS. Let's go from left to right. Ms. Garrick.

[The prepared statement of Mr. Mansfield, with attachments, appears on p. 99.]

#### STATEMENT OF JACQUELINE GARRICK

Ms. GARRICK. Jacqueline Garrick from the American Legion.

Mr. STEARNS. Okay.

Ms. GARRICK. Mr. Chairman and members of the committee, good morning.

Mr. STEARNS. Good morning.

Ms. GARRICK. The American Legion is grateful for the opportunity to comment on the Department of Veterans Affairs report on maintaining capacity to provide for the specialized treatment and rehabilitative needs of disabled veterans since The American Legion does have several concerns.

Public Law 104-262, section 104 mandates VA to protect its capacity to meet the specialized treatment and rehabilitative needs of disabled veterans within existing appropriations. The law is aimed at maintaining capacity in a manner that provides access to care for spinal cord dysfunction, blindness, TBI, amputations, seriously mentally ill, including substance abuse, homelessness, and PTSD. However, the Balanced Budget Agreement requires VA to meet this challenge with no significant increase to its buying power.

The American Legion questions VA's ability to do more with less in these highly technical and complicated treatment arenas. The American Legion commends Congress for its foresight to ensure that the scope and quality of these specialized programs are maintained. VA is often the only local provider, and is the unparalleled national leader in providing these services. Monitoring these programs is particularly important in light of VA's challenge to maintain capacity with a budget that will not keep up with medical inflation. It is hoped that, by monitoring these programs, any problematic circumstances such as inaccessibility can be identified, and corrected by VA.

The challenge to maintain capacity begins in defining capacity and how to effectively measure it. Preliminary monitors have included the number of unique individuals treated and dollars expended with consideration being given to bed levels and FTE. There is consensus that outcome measures should be used in determining the capacity in the future. While The American Legion concurs with the importance of outcome measures in assessing capacity, it also believes there is merit in continuing to monitor within the current parameters. The American Legion recommends measuring capacity by evaluating resources expended with patients treated, and then documenting outcome. According to VA's report, capacity as measured by the number of unique individuals served nationally in the programs has been maintained. Capacity, as measured by resource expended, has dropped in some cases. While the American Legion recognizes VA's ongoing commitment to these programs, there have been gaps in maintaining capacity.

In two networks—8, headquartered in Bay Pines, FL, and 18, headquartered in Phoenix, AZ—there are no long-term mental health services available at all. The American Legion views this as an inequitable distribution of capacity, in spite of the overall national average being maintained. This does not seem to be a logical conclusion, nor does it seem to be in keeping with the spirit of the law.

The American Legion is also concerned with the definition of access used by VA as being limited to timeliness. The American Legion VA Local User Evaluation workbook—or V.A.L.U.E. book, as we call it—defines access by “the key characteristics of market penetration broken down into both medical groups under VERA, as well as by the seven priority groups and the quantifiable measures aimed at providing the most accurate picture of the availability of healthcare services, such as timeliness of appointments and availability of diagnostic services.” If VA only measures timeliness, it does not get a full perspective of veterans’ access to VA’s specialized programs.

The main criticism of this year’s capacity report to Congress is the unreliability of the data. Both advisory committees and the Paralyzed Veterans of America have noticed serious shortcomings with the data collection. Obviously VA’s efforts to monitor these specialized services are contingent upon its ability to garner accurate data. In our written statement, The American Legion outlines in detail discrepancies in data found during a February 1998 site visit to Cleveland, OH and the response to that report from the network director. This experience, also, leads us to question the final report.

The American Legion sits on the VA’s Consumer Council for the Committee on the Care of the Severely, Chronically Mentally Ill Veterans. It was involved in the development of a second annual report to the Under Secretary for Health in February. The American Legion praises the SMI committee for all its work on behalf of veterans with disabling psychiatric disorders, and refers Congress to its comments on capacity. In addition, the SMI committee report also included the fiscal year 1997 report from Dr. Robert Rosenheck on the mental health performance monitoring system. The American Legion finds this to be a significant reporting mechanism and has referred to it several times when conducting its own site visits. A mental health report card is a valuable tool in assessing quality of care which is a crucial element in assessing capacity. Capacity becomes meaningless without incorporating quality and patient satisfaction.

In sum, the American Legion finds the VA report on maintaining capacity to be flawed in its methodologies and conclusions. It is incomplete since it is unable to report on outcomes. Capacity cannot be defined without understanding quality. The American Legion urges VA to utilize the expertise it has within its own resources like the National Center for PTSD and develop appropriate outcome measures. These measures should be instituted in conjunction with existing input measures and not replace them. Yet, the overarching concern for capacity begins with the Balanced Budget Agreement, and VA’s ability to continue to provide specialized care to all veterans who will need it in the 21st century.

Mr. Chairman, that concludes this statement and I will be happy to answer questions.

Mr. STEARNS. Thank you. Mr. Wannemacher.

[The prepared statement of Ms. Garrick appears on p. 125.]

#### STATEMENT OF RICHARD WANNEMACHER

Mr. WANNEMACHER. Good afternoon—or good morning, I guess. Thank you very much for allowing us to present—I brought Mr. Jerry Stillman to the table with us because he heads up and supervises 195 different hospital service offices throughout the Nation. He may have some insight although he's not here for testimony.

I'm pleased on behalf of the Disabled American Veterans, our over 1 million members of the men and women who served this country and became disabled. The DAV, AMVETS, Paralyzed Veterans of America, and Veterans of Foreign Wars, as you know, have joined together for 12 consecutive years to present the independent budget. In the independent budget, we've addressed under the medical care section, specialized services. Some specialized services are special because of the population they serve, while others are special under section 1706 of 38 United States Code. Because our four organizations work closely together each year, we have agreed to limit our testimony today to specific areas which we're most familiar. You've already heard from Paralyzed Veterans of America and their insight as to the problems in the SCI units.

The DAV has been honored with the opportunity to serve on both the Advisory Committee on Prosthetics and Special Disabilities and on the Consumer Council for the Committee on the Care for the Severely Mentally Ill. In the past, prosthetics funding has been centrally based as you heard earlier. As you've heard Mr. Miller mention, this centralized funding base is allowing for an increase in the delayed orders. The delayed orders have increased since 1996 when section 1706 38 U.S.C. was enacted. The increase in delays are unacceptable.

We're also concerned that with the flat-line appropriation, staffing shortages within prosthetics and sensory aid services are contributing to the increase in. Additionally, funding shortages do not allow for local site visitation, staff training, and monitoring of services delivered. Internal pressures are being placed on clinicians and managers who provide prosthetic sensory aids and the delayed prosthetic order report is unacceptable.

Mr. Chairman, this dilemma cannot be allowed to continue. Veterans whose orders are delayed and those who cannot timely obtain artificial limbs, supplies and devices, wheelchairs, eyeglasses, hearing aids—are being further delayed in their rehabilitation and return to gainful and competitive employment. In an attempt to fill vacant prosthetic service personnel positions, local VA medical centers are transferring other personnel within facilities who are untrained and unable to fulfill VA's commitment to these men and women who rely on VA healthcare to improve their functional abilities. We recommend that VHA centrally retain sufficient prosthetics and sensory aids funds and allocate those funds—or excess funds—to other VISNs in order to insure that there are no delayed orders.

VHA also must add at least three full-time equivalents in the strategic healthcare group on prosthetics and sensory aids at VA headquarters. VHA clinicians must be allowed to prescribe prosthetic devices and sensory aids based on medical need and not on cost. VISN Directors must ensure that prosthetics and sensory aids departments are fully staffed by appropriately trained teams and directors. Under seriously mentally ill, and as a member of the Consumer Advisory Committee, the full committee presented its first report in September 1997, making 17 recommendations.

As part of this most timely hearing, just want to note a few here this morning. The Committee was asked to review the proposed bed program closures and policy proposals and reinvestment of savings in providing a continuum of care for the seriously mentally ill. The Committee utilized data from the Northeast Program Evaluation Center, NPEC. The Committee has publicized successful consumer programs, both at VA and non-VA. They also asked for the promotion of anti-stigma training related to mental illness for VA medical centers to include personnel from areas other than mental health programs. They also asked for the reviewed policy such as pharmacy protocols and confidentiality guidelines that affect persons with mental illness. They also ask to have an input into the development of measures of customer satisfaction. They want to have mental health measures within the VISN Directors' performance evaluations. The Committee cares for veteran mental health consumer council formation at every VA facility as well as at VISN level. They also want to help develop a nationwide network of VISNs of mental health consumer councils.

Many of these questions were asked last year and accomplished. But there are a few were not accomplished. In the second report, the Committee continued to ask that VHA staff CBOCs with mental healthcare providers who can meet the special healthcare needs of this specialized service population. They also ask that the Under Secretary authorize a survey of clinical management at all psychiatric facilities that have been consolidated within the last 3 years in order to determine where that money has been spent. Has it gone to mental health? Has it gone to outpatient services? Where has it gone? They also ask that each VISN prepare a brief addendum to their business plan that addresses their achievements and transformation in implementing mental health services.

The DAV and other service organizations feel that the Medication Formulary is part of access and capacity. As you well know, we asked for a moratorium on the Formulary and a study of its implementation. We're continuing to ask that that the study address questions such as quality devices are being given to persons with specialized disability needs. Are catheters going to leak on a veteran whose confined to a wheelchair. Is the wheelchair going to be delivered in a timely manner. That's something the veterans' organizations are asking that someone address and look into.

You also heard today there are many new problems with delivery of specialized services. We're asking that this committee continue to enforce 1706 and not allow the Veterans' Administration to diminish services to specialized veterans. Thank you.

[The prepared statement of Mr. Wannemacher appears on p. 129.]

Mr. STEARNS. We have a vote here. We have several things we could do. If you folks would be willing to wait until we've come back. Another possibility is that Mr. Miller and Mr. Warfield could put their opening statements as part of the record and perhaps give an abridged version in the next couple of minutes; we could let each of you have your opening statement. I think from what I see the opening statements are pretty powerful and compelling in themselves. I'm sort of receptive to what you want to do. We have a vote which would be 15 minutes. Then we have another vote after that which would be anywhere from 10 to 15 for those two. So you're looking at 30 minutes before we would reconvene. Now we could adjourn this and come back at 1 o'clock, I'm very receptive. I would say—

Mr. MANSFIELD. Mr. Chairman, after a quick review here at the table I think the two folks that haven't testified have the bigger vote. We'd like to come back.

Mr. STEARNS. Okay. This is a little bit—I think the testimony is just so compelling—it's a little unusual, but I would like Dr. Garthwaite to perhaps stay to listen to this testimony. If in fact he still feels that this is a problem, I'd like to know what he's going to do about it. Because I think this is, the bottomline is, you're giving these compelling arguments. We want to hear from him how he feels and what he's going to do because then Congress obviously has an obligation after hearing this to do something. I mean, that's my take on this. So I think if that's what we'll do, then would you rather wait and get your full opening statements after we come back. Then perhaps why don't we do this so everybody can get some lunch and we can all get things done. We'll be a half-hour voting and then we'll take some lunch. Why don't we reconvene then at 1 o'clock and continue? Will that be satisfactory?

Mr. MANSFIELD. Thank you, Mr. Chairman.

Mr. STEARNS. Okay. Thanks.

[Recess.]

Mr. STEARNS. Perfect. I want to thank the third panel for continuing to stay with us. I appreciate their indulgence and we welcome continuation of the testimony. At this point, Mr. Warfield, your opening statement.

#### STATEMENT OF WILLIAM WARFIELD

Mr. WARFIELD. Thank you, Mr. Chairman. I appreciate your patience for allowing us to appear. My name is Bill Warfield. I'm here to represent Vietnam Veterans of America. I will try not to be redundant and duplicative of the excellent testimony you've heard today from my colleagues. I'm honored to be up here with them. We work in these trenches together day in, day out on behalf of veterans.

On the data testimony, I strongly support and conclude that there are problems with this data. Management systems—I think there are deficiencies there. I agree with my colleagues. There are a couple of other things that I'd like to mention in my statement. Our moral and legal responsibilities are now and always should be to provide the highest and best standards of care in treatment for veterans who gave so much in defense of America. That obligation must not be eliminated nor shirked by those who make our laws

at the Federal level and those whose duty it is to enforce those laws.

A strong perception and reality has surrounded this government like a deadly fog as part of the general lowering of government's priorities and ranking of care and concern about our veterans. This sad decline became a reality when the majority of the Congress and the President this year took scarce budgetary resources from VA—estimated to be \$15 billion for payment of disabled veterans, widows and orphans. They used it to payoff high-rolling transportation interest group projects. Those of us who work everyday to protect those who were wounded in line of duty must make our voices heard loud and clear by the Americans who vote in November. We need to elect members who will support veterans.

The ongoing trend of reductions in VA budget resources continues. As we speak, there's a Kasich budget plan that will have adverse effects on future 5-year budget projections for VA. These trends are especially troublesome for special needs programs, such as medical care for seriously mentally ill and PTSD treatment. What will happen when the supply and quality of medical services for people who suffer from serious mental illness, veterans, and related chronic conditions and reduced disability ratings are imposed by VA?

I would like to move away from the data because you've had adequate testimony on the data. Really sort of conclude by saying that we could not disagree more forcefully with a policy which is totally driven in the wrong direction. This is a dollar-driven policy. Such bottomline policies will produce adverse consequences nationally for special care needs. They are shortchanging veterans everywhere, in every category. But they are especially harmful for veterans who are poor and who suffer multiple health problems related to mental illness. VA is not solely responsible for this retreat from our 200-year Federal commitment to care for veterans.

Other players like OMB, and CBO has forced the VA budget into near starvation. All in the name of deficit reduction, but at what cost? Should the health and well-being of veterans be transferred to Blue Cross/Blue Shield, Kaiser Permanente—there are many on the Hill who have told me that they should be—or even State and local government? We say a resounding no. But the end results of consolidations, decentralization, and cost reduction is by default shifting the burden and responsibility for the care of veterans who earned that care to non-VA programs.

Worse yet, those hardest hit are veterans who once got good care and needed at least some inpatient support to receive therapy. We've heard today that in many VA VISNs and facilities, inpatient treatment and care for residential PTSD and the seriously mentally ill is a vanishing commodity. We certainly regret that. We have confirmed the numbers of homeless veterans is growing. In fact, more than 275,000 veterans are estimated to be homeless on any given night of the year. Despite this shocking fact, less than 3 percent of all of the more than \$1 billion spent every year by HUD is allocated for veterans who are homeless. The myth that the VA is meeting all of the needs for all of America's veterans is still pervasive, but it's very wrong. Only 10 percent of the veterans receive even moderate care now.

We urge this committee to work with us and other VSOs to do more in-depth, impact field and case management studies to find out the true impact of these changes. The best way to get the truth is for you, as representatives which you've done, to go to your districts to visit first-hand VA hospitals, clinics, vet centers. In your home areas, talk to veterans who use the VA healthcare system. Talk to the local healthcare providers who care for veterans, and talk to VSO service reps who have great insight. Make your own studies, conclusions, and fact-finding missions. Listen to the real people back home and discount most of the inside the beltway, bureaucratic, mumbo-jumbo and academic nonsense.

That concludes my statement. I'll be glad to answer questions. Thank you, sir.

Mr. STEARNS. Thank you, Mr. Warfield. Would staff just take his name tag and just put it up if you would. Mr. Miller, we welcome you again with your opening statement.

[The prepared statement of Mr. Warfield appears on p. 134.]

#### STATEMENT OF THOMAS H. MILLER

Mr. MILLER. Thank you very much, Mr. Chairman. I don't know what Bill had for lunch, but I don't think I had the same thing. We try to get him excited. Mr. Chairman, I would like to thank you from the Blinded Veterans Association for holding this very, very, very important hearing. We're very concerned about the specialized program and services VA offers for our Nation's blinded veterans the impact the new VHA—and reorganization—is having on those programs.

I was very gratified this morning to hear Dr. Garthwaite acknowledge—at least in the sense that there may be problems—by announcing the establishment of a special panel to look into the blind rehabilitation programs and services. We certainly pledge to work closely with that group and hopefully we'll be a part of that and can come up with some solutions to determine just how the specialized programs can fit into the veterans' integrated network concept.

In my written statement that request be submitted for the record, I went into some detail regarding the three distinct programs the VA offers for blinded veterans. I think in some of the data collection, problems that were identified earlier and that we discussed—it's difficult when you look at their data to distinguish between programs and programs within programs which is very important when it comes to capacity. The three distinct programs of blind rehabilitation centers which are residential or inpatient comprehensive blind rehab programs.

The visual impairment service team program, which you heard Dr. Gross refer to, those are managed care, case-managed ambulatory care programs to ensure the comprehensive delivery of service to blinded veterans. In a new program, the blind rehabilitation outpatient specialist is also an outpatient program. Some of the data that VA collects rolls all those numbers together so it's impossible to determine whether there's been a negative impact on the inpatient residential program because of other numbers that are folded in with that. So we feel that it's imperative that data collection and data management problems be identified, clarified, and worked out

on a national basis. There needs to be consistency across the system.

One of the most frustrating things for us has been with the organization of the VA system and the 22 integrated service networks is that the differences that have occurred, the level of understanding from network to network about our programs, what they do, and what the expected outcome should be. Some network directors have stated openly they don't understand why blind rehabilitation can't be done on an outpatient basis. It's too costly to put a blinded veteran into a hospital and keep him in a residential program for 4, 6, 8, 10 weeks—whatever the length of the program may be.

As a consequence, there are a couple who are in fact discouraging referral to the residential programs and insisting that the coordinator's refer blind veterans to local resources which are totally inadequate to meet the comprehensive needs and are certainly not comparable to those of the VA. Others have mentioned the decisions that are being made are cost-driven. Our concern with the blind rehabilitation program—the inpatient services—in an effort to increase capacity, they're reducing—increasing pressure to reduce the length of stay. The length of stay of the program is critical as to whether the veteran is going to optimize benefit from that program.

This is an example. I went through VA's blind rehab program 30 years ago—I know I don't look that young—but the average length of stay at that time was 18 weeks. Now, we're looking at around 8 weeks. That's a substantial reduction in length of stay. For the most part, that's happened naturally because of the change in the veteran population that they're dealing with in the blind centers and they've modified and adjusted programs to address the current needs of—excuse me—being served. Unfortunately, local managers are increasing pressure to reduce those length of stays even further.

Our vets coordinator positions are absolutely crucial to identify blinded veterans, plugging them into the system, and assuring that they're getting the services that they need to overcome the handicap of blindness. When some of those positions become vacant, the first thing local managers are looking at is eliminating them altogether or reducing them to half-time. We've got 30 years of experience with that program. The first six were with those coordinators functioning part-time. We learned very quickly that part-time was not adequate.

Back to the blind center, Dr. Garthwaite we're celebrating the 50th anniversary of the VA blind rehabilitation service and the first blind rehab center that was opened in Hines, Illinois. We have 50 years of experience. We have a program that's been the premier provider of residential blind rehabilitation in the world. The VA has served as a model around the world for other countries to develop their services for their blind citizens. We know it works; we know, once outcome data is available that will validate the anecdotal information and what we all know, those of us who've had the opportunity to go through those programs can tell you about the quality.

Finally, I think I'd like to conclude by reinforcing that these are national programs. There needs to be national standards and na-

tional guidelines, and some mechanism to monitor the funding of these programs on a national level. It's unfortunate that as a national program the full burden falls on the local medical center. When they have to take reductions in their FTE, they do it across the board so that a blind rehab center will have to take its share of the cuts. Well that center doesn't serve only that local hospital, it serves the entire network, multiple networks and maybe up to 30 or 40 medical centers in their geographic catchment area. So that burden needs to be shared.

I don't believe the funding mechanisms at this point are adequately compensating, reimbursing the local facility so they can take a heavy responsibility fiscally to maintain these specialized programs. If not central funding, some other mechanism has to be developed in order to relieve them of that burden to enable them to allow these programs to function with optimum staffing levels and resources so that they can maximize the number of veterans that go through the program without compromising the quality of the service. That concludes my statement, Mr. Stearns. I'd be glad to answer any questions.

[The prepared statement of Mr. Miller appears on p. 145.]

Mr. STEARNS. I thank you, Mr. Miller. As you know before we broke, I mentioned that we would like Dr. Garthwaite to come back. He has indicated he cannot come back and I didn't push it. But he has said he is committed to providing a response to some of what I believe is compelling arguments that you make here this afternoon. Myself and staff are going to follow-up with him with some questions, and ask him for specific steps that the VA should take to solve the problems we've heard about today. So I think your testimony has been very helpful. We appreciate you coming.

(See p. 159.)

Mr. STEARNS. I have a few questions. I'll just give you my thought on an overview here. We have another vote in less than 15 minutes. What I'd like to do is go around shortly with some of my questions. Then my colleague from Florida, Mr. Bilirakis, let him ask some questions. But we're sort of moving towards the idea of adding legislatively some appropriate performance measures for the VISN Directors and hospital directors' performance contracts. I guess the question I would have, Mr. Mansfield, is do you think possibly legislative measures regarding appropriate performance measures for VISN Directors' and hospital directors' performance contracts would make a difference?

Mr. MANSFIELD. Mr. Chairman, I think it would. There are some concerns, you know, about how far down the management ladder you can go, and what you can do in legislation—how would you make that work. But I think that Congress has to make sure that managers in the VA understand all the way down as far as you can go that they've got to take care of veterans with specialized needs. That's what their mission is. If performance measures are what they're paying attention to, and unfortunately, I think in the new system that's what they are paying attention to, then we probably need to affect the things that affect them. I would say yes, let's go ahead.

Mr. STEARNS. I came from the private sector. Whenever large corporations or small corporations ran into problems that they

could not get sufficient objectivity, they would go to Price Waterhouse. Or they would go to MacKenzie Consulting Companies and ask them to come in to do something. Now we have the GAO doing a report. A lot of people would argue that the GAO would do a good job. But others will argue that maybe we might even need a more objective outside professional accounting firm. The GAO is going to point out the problems, but they're not necessarily going to come up with the solutions.

So, frankly I see the problem as a little bit of consistency of performance standards bearing management ability here. I'm very sympathetic to the fact that the balanced budget put a constraint on the cost here. I'm not sure what I can do about the latter. But I would suggest that we need some more information and perhaps legislatively, the performance measures would be good. But perhaps even having an outside consultant come in and tell us from a management standpoint what could be done. Let me switch to Ms. Garrick. How would you grade VA compliance with the "maintain capacity" requirement at the VISN level?

Ms. GARRICK. How would I grade it?

Mr. STEARNS. Yes. How would you grade the VA's compliance? In other words, in your opinion is it an F or an A or C?

Ms. GARRICK. Well, it sounds like it's hovering somewhere just above an F.

Mr. STEARNS. I mean, that's—from our testimony, we just wanted to help you quantify your feelings.

Ms. GARRICK. Well, obviously, the American Legion is disappointed in that we do see capacity as not being equitable. With equity being such an influence in the budget under VERA—VERA is supposed to be about equity—well, so should capacity and access and timeliness and quality. Those things should also be about equitable distribution. If there are veterans and VISNs, like 8 and 18, Florida and Arizona where there's no long-term mental health, that's not equity. That's not equity in capacity and it certainly isn't equity in quality.

Mr. STEARNS. Let me just ask each of you. If I recommended that the VA obtain an independent management review to corroborate the information, would any of you have an objection to that? Going outside? Yes, sir, Mr. Warfield.

Mr. WARFIELD. Yes, sir. If I may, with all due respect. There have been probably 15 or 20 outside consultant firms, including Price Waterhouse, NAPA studies—the Appropriations Committee frequently does this. VSOs have done this. There have been internal studies. There's voluminous documentations—

Mr. STEARNS. On this subject?

Mr. WARFIELD. Yes, sir. Sir, I think we know the problem. We've identified the problem here. I think it can be documented. I think that we also have touched on the solutions to the problem today. I think that going down to the—as I recommended in my testimony—go down to the local level and talk to the people who are using the services and practitioners who are delivering this service. You can find out pretty easily what's gone wrong.

Mr. STEARNS. You think the idea of us legislating performance standards with both the VISN Directors and also the administrators of the hospitals would help?

Mr. WARFIELD. No, sir. It's already being done. There are 24 different standards. As an example to those performance standards, the VISN Directors will administer certain diagnostic tests on mental illness; put it in the file, and have a 97 percent compliance rate for performance and receive perhaps a bonus award for doing that. So follow up of mandatory or statutory performance standards, is well-intentioned, reasonable, but it's not really going to be implemented by a bureaucratic, uncaring agency.

Mr. STEARNS. So you're saying we have to go down to the grass root level.

Mr. WARFIELD. That's my recommendation. Yes, sir. Field hearings—

Mr. STEARNS. Implement it?

Mr. WARFIELD. Yes, I do.

Mr. STEARNS. That's how you sum it up. Okay, Mr. Bilirakis.

Mr. MANSFIELD. Mr. Chairman, I think you indicated you're going to ask each one of us to respond to that question.

Mr. STEARNS. That's fine. Okay. We have probably about 7 minutes to vote.

Mr. MANSFIELD. Real quickly, I would say this. I understand where my colleague's coming from. But I would suggest we work on two fronts. Number one, I think you know what you need to move this Congress to act and if you think mandating performance measures is part of it, then it might be a plus. The second thing is, rather than just talking about the capacity issue here, by itself here it might be time for the Congress to study this whole change that's going on within the VA, including the move to VISNs. In the context of that, if you did it, I think if you looked at the programs we're talking about here as national programs and examined what happened to them in this change, it might be important.

Mr. STEARNS. Okay, Mr. Bilirakis.

Mr. BILIRAKIS. Well, Mr. Chairman, I guess the big problem as I see it is veterans' healthcare and veterans' programs getting caught up in the political picture where you have changes every so often in administrations which means changes in terms of the Secretary. But you know, when we talking about maintaining and meeting the requirement for specialized services. Let me go to the SCI Center in Tampa, for instance. I understand that VA has at least one representative in the audience taking all this in, which is good.

I have visited that center many times over the years. They have so many beds for SCI patients. The beds are not enough because of the wide area they cover. Someone would say, well it has 70 beds. We've been maintaining those 70 beds, et cetera, et cetera. Yet those beds are scattered over many floors—not all on the first floor where there should be. If there is a fire or something like that, God forbid, at Haley, I don't know, Gordon, if we could ever evacuate those people. I know they've been up to as high as the 5th floor. We're talking about SCI patients being evacuated from the 5th floor of the hospital. Now I think they're only going up about two floors right now. This expansion that we're talking about would have the SCI center on the first floor where it should be. So, you know, again if we take a look at, or we talk about data, we take a look at statistics and things of that nature that data or the sta-

tistics might meet the requirement. But really in practice in the real world, is the requirement being met when they're scattered throughout all these areas. I think it's probably what Mr. Warfield is saying and the rest of you that it's got to be down at that particular level.

Mr. STEARNS. Yes, sir.

Mr. BILIRAKIS. Well, we're going to do the best that we can here. But you know, the trouble is we change all the time, too. You have a chairman of the subcommittee—who knows next session whether he would be the chairman or there might be a change. I guess that's really what makes the job so darn difficult for everybody, including the people in the VA and the fact that there are changes that constantly take place.

Mr. STEARNS. Well, I didn't get to hear all your testimony because it's a heck of day for me, as it is for all of us but we thank you. It's obviously been very helpful.

Mr. WANNEMACHER. Could I just say one thing?

Mr. STEARNS. Yes, sir.

Mr. WANNEMACHER. If you are going to do performance measures, make sure that performance measures also address seriously mentally ill. I mean, how they're treating seriously mentally ill veterans. What I think Bill was talking about, though—going to the grassroots—we don't hear a lot, the DAV doesn't hear a lot from our veterans as far as improper care problems. Only because at the front door, they are told this is the way it's going to be and this is what you're going to get. They've accepted that. They go outside for other services.

But if you—well, like what Bill was saying—if you went to the grassroots. I have physicians that are calling me from throughout the Nation, VA physicians, telling me the horror stories out in the State of Washington, down in the State of Florida, out in Utah. There is a real problem out there about morale within the system. These people, because they're short-staffed, just don't feel that they're being provided the tools and the time to provide quality healthcare. You've got to go to the grassroots. Not from some analysis from here—what you read in the directives from Dr. Kizer, read real well. But the implementation of these directions in and there impact in the field is eye opening.

Mr. STEARNS. I had a hearing out in Boise, ID.

Mr. WANNEMACHER. You know what you heard there.

Mr. STEARNS. That was an eye-opener. So I understand it. Again, thank you for staying over for the reconvening. We have to rush to a vote. I appreciate your testimony. We'll stay in touch here.

Mr. MILLER. Thank you, Mr. Chairman.

Mr. WARFIELD. Thank you, Mr. Chairman.

[Whereupon, at 1:26 p.m., the subcommittee adjourned subject to the call of the chair.]

## APPENDIX

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STATEMENT OF LANE EVANS  
HEARING ON SPECIALIZED TREATMENT AND  
REHABILITATIVE NEEDS  
OF DISABLED VETERANS  
JULY 23, 1998

Mr. Chairman, I sincerely thank you for holding this important hearing today. As you know, some time ago I asked the General Accounting Office to review VA's success in maintaining its capacity to provide specialized services for disabled veterans. I am pleased GAO has now begun this study. Hopefully today's proceedings will offer them some further insight into the substantive examination GAO will continue, following today's proceedings.

"...it should be kept in mind that while the environment in which VA now operates requires that greater attention be given the financial management of the system, this should not be *misinterpreted* as a change in focus or a commercialization of VA's mission. VA will continue to uphold its long tradition of *advocating for the sick and vulnerable, and of putting the patient's welfare first*" {emphasis added}. These prophetic words are not mine, but the Undersecretary for Health, Dr. Kenneth Kizer's. You can find them on page nine in the guiding principles of VA's *Prescription for Change*. Judging from the testimony, it's time to re-issue this guidance to all Veterans' Health Administration officials. Notwithstanding special legislative protection Congress enacted to ensure that capacity in these programs is maintained, the testimony we will hear from both the veterans and the experts indicates VA has, in large part, not provided this protection.

I am not here today to quibble about numbers although from almost any point of view the numbers VA has provided Congress appear severely flawed and this hampers our ability to make policies and oversee these important programs. I most strongly object, however, to the apparent lack of regard VA has given to abiding by the “spirit” of the law. If VA managers were conveying the importance of the specialized services to care practitioners, I doubt there would be much genuine concern about how to measure capacity and access. Testimony indicates that management may not be conveying the importance of these services. Compounding the problem is the fact that distribution of VA’s specialized services does not correspond to the current network management structure. Some programs, like Spinal Cord Injury and Blind Rehabilitation, are national in their scope. Without transfer pricing in place, some VISN directors responsible for expensive specialized services must truly be questioning their ability to care, not only for their own veterans, but for veterans from other networks. Some, particularly those without a strong VA background, must truly consider it unfair that they must assume the cost of expensive inpatient stays of veterans from other networks and consequently be looking to scale back services so they are only required to “care for their own”.

Decentralizing VA management and taking away any authority VA service chiefs once had for ensuring the integrity of these programs may be largely to blame for these programs disintegration. Once these programs offered the “state-of-the-art” in managing care for some types of disabilities, particularly for combat injuries. With no effective VA oversight of these programs, they now seem to be falling into disarray, and, I hope those of you here today from VA will take this message back to Dr. Kizer—neither *rhetoric* nor law seem to be doing the trick in

inspiring managers' attention. In a new era where performance measurement rules, VA managers with power over resource distribution are not evaluated for ensuring the integrity of the specialized services. VA should include these measures in someone's performance contract before Congress is compelled to revisit fenced budgets as a means for ensuring the needs of our disabled veterans are adequately met.

What is worse, testimony from the Chairman of the VA Federal Advisory Committee on Special Disabilities and Prosthetics and some of the VSOs indicate that VA may be taking steps to hide the truth about its inability to maintain these programs from Headquarters and Congress. Specifically, the Chairman indicates that prosthetic orders are being significantly delayed and managers are under severe pressure not to request additional funds to avoid shortfalls for orders. It seems that no one wants to admit they need more money when it may connote a failure to manage within a budget to his or her peers and forfeits the possibility of performance-based pay. What a misnomer.

The news from the Committee on Care of Severely Chronically Mentally Ill Veterans is no better. While VA is offering more veterans mental health services, they are treating fewer of the very sickest of these veterans—those that most need our help. Continuity of care for those receiving services is suffering. Variation between networks is tremendous. It is as if VA learned nothing from the country's miserable experience with de-institutionalization in the 1970's and 80's. VA continues to eliminate beds where no community resources exist to replace them.

Paralyzed Veterans of America has an aggressive program to monitor resources devoted to Spinal Cord Injury. They claim that the baseline from 1996, which VA has already lowered, was already underestimated. They further assert that, in VHA's current state of restructuring, there is a confusion about new management structures and unfilled staff vacancies that often translate to a crisis in the leadership of services. I could go one, but we will hear far more from the witnesses themselves.

Incentives seem to be leading VA managers and practitioners to make bad patient care decisions. Let me say that I know there are many dedicated employees in the VA who are working overtime to meet veterans' needs with too little money to do it. What I am questioning is the type of incentives and structures that VA has put in place to engender the poor response to special programs that will be attested to today. There are many solutions VA could consider to better ensure their operational integrity and if VA is unable to find them it may require Congress to fill into this void.

In the Marines we have an expression—"Leave no man behind". I respectfully submit to VA that if the "new VA" is abandoning responsibilities for caring for our sickest and most vulnerable veterans, additional scrutiny of the future of VA would certainly not be surprising. These programs are the heart and soul of the VA - if these vital organs are not sound the VA's viability may be in question. We must remember, VA *is* the safety net. If we don't meet the needs of the hardest-to-treat, no one else will. VA must do a better job to ensure that it honors its covenant to disabled veterans—those most vulnerable to the fluctuations of funding and most in need of our help.

Mr. Chairman, this concludes my statement, but I ask for the record to remain open for a week so that I may revise and extend my remarks. Thank you.

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**GAO**

United States General Accounting Office

Testimony

Before the Subcommittee on Health, Committee on  
Veterans' Affairs, House of Representatives

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For Release on Delivery  
Expected at 9:30 a.m.  
Thursday, July 23, 1998

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## VA HEALTH CARE

# VA's Efforts to Maintain Services for Veterans With Special Disabilities

Statement of Stephen P. Backhus, Director  
Veterans' Affairs and Military Health Care Issues  
Health, Education, and Human Services Division



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**GAO/T-HEHS-98-220**

Mr. Chairman and Members of the Subcommittee:

Thank you for the opportunity to be with you today to discuss our ongoing work on the Department of Veterans Affairs' (VA) efforts to comply with section 104 of the Veterans Health Care Eligibility Reform Act of 1996 (P.L. 104-262, Oct. 9, 1996). This provision reflects concerns that budgetary pressures and ongoing reorganization within VA might make VA's specialized programs and services for disabled veterans vulnerable to cost cutting. The provision requires the Secretary of VA to (1) ensure that the systemwide capacity of the department to provide specialized treatment and rehabilitative services is not reduced below its October 1996 capacity and (2) provide veterans with reasonable access to such needed care and services. The provision identified four disabling conditions; VA, after consulting with stakeholders, identified two additional conditions.<sup>1</sup> Further, VA is required to report to the House and Senate Committees on Veterans' Affairs annually on its compliance with section 104 from fiscal years 1997 through 1999.

You asked that I focus my remarks on whether VA (1) is maintaining capacity with reasonable access to specialized care and (2) has data that is sufficiently reliable to monitor and report on compliance. My comments are based on meetings we have held with VA officials responsible for administering the special disability programs, officials of veteran service organizations (VSO) that represent the veterans receiving specialized care, and representatives of two advisory committees with which VA is required to consult in responding to this legislation.<sup>2</sup> We are also reviewing VA and advisory committee reports, relevant policies and manuals, and other data and documentation. We will be continuing our work over the next several months and expect to issue a report next spring.

In summary, our work to date suggests that much more information and analyses are needed to support VA's conclusion that it is maintaining its national capacity to treat special disability groups. For example, while VA's data indicate that from fiscal year 1996 to fiscal year 1997, the number of veterans served increased by 6,000 (or 2 percent), the data also show that spending for specialized disability programs decreased by \$52 million (or 2 percent). VA attributes the decreased spending to reducing unnecessary duplicative services and replacing more expensive hospital inpatient treatment with outpatient care. Such aggregate data and assertions may, however, mask potential adverse effects on specific programs and locations. For example, VA data also show that the number of veterans treated systemwide in fiscal year 1997 decreased for amputees, and expenditures were reduced for veterans with amputations, serious mental illness, and PTSD. In addition, for substance abuse patients with serious mental illness, VA data show that about 3,000 fewer veterans were served and \$112 million less was spent.

Consistent with the Government Performance and Results Act (GPRA) of 1993,<sup>3</sup> VA plans to develop outcome measures over the next 2 to 3 years to track whether, among other things, the care provided to disabled veterans is effective as a result of its shift from inpatient to outpatient care. VA intends to replace expenditure data with outcome measures when they become available. While outcome measures are a valuable tool to evaluate program effectiveness and to help monitor physical, psychological, and social services, retaining current measures, such as dollars spent serving VA's special needs population, are also important to measure legislative compliance.

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<sup>1</sup>The four conditions identified in the statute are spinal cord dysfunction, blindness, amputations, and mental illness. VA limited its program for mental illness to veterans with serious mental illness and added two other programs—traumatic brain injury and post-traumatic stress disorder (PTSD).

<sup>2</sup>The two committees are the Advisory Committee on Prosthetics and Special Disabilities Programs and the Committee on Care of Severely Chronically Mentally Ill Veterans.

<sup>3</sup>GPRA requires agencies to prepare annual performance plans covering program activities set out in their budgets beginning in fiscal year 1999.

Beyond the issue of how VA chooses to measure its capacity to serve veterans with special disabilities, there are also questions regarding the reliability of VA's data. For example, in 1998, VA reduced its reported 1996 baseline expenditure data in all six specialized programs and services by as much as 50 percent without explaining in its report the basis for such changes. VA's two advisory committees have also raised questions about anomalies in the capacity data. VA has acknowledged the need to improve its data systems and has several efforts under way to do so. We will be examining data reliability issues in more detail as we complete our study.

## BACKGROUND

VA has taken steps to fundamentally change the way it delivers health care to the nation's veterans. In recent years—and consistent with major changes in the national health care industry—VA has moved toward providing more services to veterans on an outpatient basis. Also, VA's Veterans Integrated Service Networks (VISN) have greater discretion for determining the mix of services to be provided. In House Report 104-600, which accompanied the Veterans Health Care Eligibility Reform Act of 1996, considerable discretion is given to the Secretary of VA in managing the provision of health care services to veterans. However, the report pointed out that the uniqueness of VA's specialized treatment programs requires a far more prescriptive response in the legislation. The report noted that providing specialized treatment and rehabilitative services is vital to VA's health care mission. Due to the recognized high cost of these programs, budgetary pressures and restructuring within the Veterans Health Administration (VHA),<sup>4</sup> the House Committee on Veterans' Affairs was concerned that "VA's costly specialized programs may be particularly vulnerable and disproportionately subject to budget cutting."

To address these concerns, a provision of the act directed the Secretary to ensure that VA maintain its capacity to serve veterans with special disabilities. This provision also requires VA to consult with the Advisory Committee on Prosthetics and Special Disabilities Programs (ACPSDP) and the Committee on the Care of Severely Chronically Mentally Ill (CCSCMI) Veterans in fulfilling the requirements of the act.<sup>5</sup> Primarily, ACPSDP advises the Secretary on issues affecting the delivery of prosthetic services to amputees and other special disability groups. The mission of CCSCMI Veterans is to assess VA's efforts to meet the treatment and rehabilitation needs of severely and chronically mentally ill veterans. VA coordinated with the committee and incorporated its input on the care of seriously mentally ill veterans. In addition, both committees worked with VA to identify the six special disability groups and to define measures of capacity and access. VA also established a Special Disability Programs Work Group to work with a number of stakeholders such as national and state VSOs, VHA networks and facilities, and special disability program managers on issues such as identification of the 6 special disability groups, their definitions, and definitions of capacity and access.

While consensus was not reached among stakeholders, VA established an initial set of 1996 baseline capacity measures consisting of the number of veterans served and dollars spent on veterans with these specialized needs. For veterans disabled by blindness and spinal cord dysfunction, capacity is also measured by the number of specialized beds and staff resources dedicated to these disabilities. VA defines access as

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<sup>4</sup>VHA has decentralized its management structure to coordinate the organization of its medical facilities into 22 networks. This was done in an effort to improve efficiency by reducing unnecessarily duplicative services and shifting services from inpatient care to less costly outpatient care.

<sup>5</sup>ACPSDP members are from veteran service organizations, universities, and private sector health care providers. In accordance with P.L. 104-262, members of CCSCMI Veterans must be VHA employees with expertise in the care of the chronically mentally ill and be appointed by VA's Under Secretary for Health.

timeliness in providing services to veterans for their specialized needs. VA is currently developing outcome measures to reflect the overall effectiveness of its programs.

**UNCLEAR IF VA HAS MAINTAINED CAPACITY AND ACCESS TO SPECIALIZED SERVICES**

VA's data show that there was an increase in the number of disabled veterans served despite an overall decrease in dollars expended for the six programs and conditions from fiscal years 1996 to 1997. Overall, 2 percent—or about 6,000—additional veterans were served with 2 percent—or \$52 million—less spending. VA's data also indicate that access improved nationally for most programs.

For five of the six programs and conditions, VA served more disabled veterans in fiscal year 1997 than it did in 1996 for a total increase of about 6,000 more disabled veterans served. Only in the amputee program was there a reduction in the number of veterans served—approximately 2 percent. Three of the six programs had higher expenditures during the same time period. The traumatic brain injury, blindness, and spinal cord injury programs experienced 68, 24, and 3 percent increases, respectively, in expenditures, although they served many fewer veterans than programs for mental conditions. (See table 1.)

**Table 1: Percent Change in Number of Veterans Served and Dollars Spent From Fiscal Years 1996 to 1997**

Program/ condition	Individuals served			Dollars expended (thousands)		
	FY 1996	FY 1997	Percent change	FY 1996	FY 1997	Percent change
Spinal cord injury	8,598	8,922	4	\$199,848	\$206,228	3
Blindness	9,726	11,726	21	43,855	54,426	24
Traumatic brain injury	175	251	43	3,735	6,271	68
Amputations	4,765	4,684	-2	5,953	5,856	-2
Serious mental illness	269,009	272,229	1	2,080,240	2,015,642	-3
PTSD	39,653	40,027	1	101,882	95,223	-7
<b>Total</b>	<b>331,926</b>	<b>337,839</b>	<b>2</b>	<b>\$2,435,513</b>	<b>\$2,383,646</b>	<b>-2</b>

Note: We did not independently verify these numbers.

Source: VA Report to Congress, Maintaining Capacity to Provide for the Specialized Treatment and Rehabilitative Needs of Disabled Veterans (Department of Veterans Affairs, May 1998).

Much of the change in expenditures involved veterans with serious mental illness, who in fiscal year 1997 account for 81 percent of the veterans served and 85 percent of expenditures for the six specialized programs and conditions. VA data indicate that it provided services to an additional 3,000 seriously mentally ill veterans, while it reduced spending by about \$65 million. VA attributes these changes to efficiencies gained from shifting the treatment emphasis from inpatient to outpatient care. It is unclear, however, whether VA's data are comprehensive enough to quantify the effect on capacity of changes in service delivery methods. Moreover, other data not used by VA, such as numbers and types of specialist providers and beds, may also be useful indicators of capacity.

Substance abuse services for veterans with serious mental illness illustrate the need for more comprehensive information to assess whether capacity is being maintained. For example, from fiscal year 1996 to 1997 substance abuse expenditures declined by 20 percent, or over \$112 million, and VA treated about 3,000 fewer veterans with this condition. (See table 2.) Some VA networks believe that such numbers give an incomplete picture of actual services rendered because patients who are "mainstreamed" into general care programs may be receiving care outside the special programs. While improved efficiencies can account for some expenditure reductions, they do not appear to explain the large regional drops and variations in the number of patients served. In fact, it seems reasonable to expect that a shift to less costly outpatient delivery modes should result in significant increases in the number of patients treated for the same expenditures.

**Table 2: Percent Change in Number of Veterans Served and Dollars Spent for Seriously Mentally Ill Programs From Fiscal Years 1996 to 1997**

Program for seriously mentally ill	Individuals served			Dollars expended (in thousands)		
	FY 1996	FY 1997	Actual change (percent change)	FY 1996	FY 1997	Actual change (percent change)
Substance abuse	107,074	104,441	-2,633 (-2)	\$575,902	\$463,372	-112,530 (-20)
Homeless	24,539	24,613	74 (0)	75,071	72,765	-2,306 (-3)
PTSD	32,142	32,575	433 (1)	99,705	92,667	-7,038 (-7)
Other*	105,254	115,600	10,346 (10)	1,329,562	1,386,838	57,276 (4)
<b>Total</b>	<b>269,009</b>	<b>272,229</b>	<b>3,220 (1)</b>	<b>\$2,080,240</b>	<b>\$2,015,642</b>	<b>\$-64,598 (-3)</b>

Note: We did not independently verify these numbers.

\*Veterans who currently have or at any time during the past year had a diagnosed mental, behavioral, or emotional disorder of sufficient duration to result in a disability-excluding those with PTSD, substance abuse and/or are homeless.

Source: VA Report to Congress, Maintaining Capacity to Provide for the Specialized Treatment and Rehabilitative Needs of Disabled Veterans.

With regard to reasonable access to care and services, VA's data indicate that access has improved for 5 of the 6 special disability programs. (See app. I.) For example, VA's data indicates that the proportion of veterans receiving psychiatric outpatient care within 30 days of hospital discharge increased by 0.6 percent in fiscal year 1997. This increase was accompanied by a 2-day average decrease in the number of days from discharge to the first outpatient visit. In contrast, monthly waiting times for admission to the inpatient blind rehabilitation program increased by 1 to 8 weeks for 11 months of the year. VA attributes increased waiting times, in part, to delays in filling vacant positions and increased demand for services.

VA is currently developing outcome measures to track the quality and effectiveness of care provided to disabled veterans. Outcome measures, such as functional status, provide an opportunity to examine the effectiveness of innovations in service delivery, which could lead to a higher degree of patient satisfaction. Outcome assessments also

provide benchmarks for goal setting and facilitate comparisons among programs and facilities from year to year. Although VA has identified preliminary outcome measures for each special disability program, it estimates that 2 to 3 years will be required to fully develop and collect data to include outcome measures in its monitoring system. (See app. II.)

As it did in its first two reports to the Congress, VA plans to use individuals served and the dollars expended for their care as its measure of capacity in its final report in 1999. However, when outcome measures are developed, VA plans to measure capacity using only the number of individuals treated in specialized units. While VA will continue to collect information on costs and expenditures for special disability programs, this information will not be used to measure capacity.

#### **MORE RELIABLE INFORMATION NEEDED**

VA is working to develop more reliable information on its special disability programs.<sup>6</sup> However, we and others are concerned about the reliability of VA's data and VA efforts to improve it. For example, VA used different 1996 baseline capacity data in its 1997 and 1998 reports to the Congress. (See app. III.) VA reduced all baseline program expenditure figures in its 1998 report, with changes ranging from a high of \$56.5 million to a low of \$300,000. While VA attributed these changes to data refinement, it did not provide any specifics in its reports as to what prompted such refinements.

Baseline expenditures for the amputee program—which VA reduced about 50 percent (\$5.8 million) in the 1998 capacity report—illustrate potential problems with VA's data. According to VA officials, the reduction occurred because the 1997 report inadvertently included in the amputations workload the amputations of toes other than the great toe, which is considered more likely to lead to a disabling condition than other toe amputations. It seems questionable, however, that this would result in baseline expenditure reductions of 50 percent in each VISN and all facilities, as VA reported.

VA's two advisory committees have also questioned the accuracy of VA's data. CCSCMI Veterans (comprised of VA employees) indicated that data problems hampered its ability to evaluate VA's capacity to treat seriously mentally ill veterans and that it is using other sources of data to aid in its assessment of capacity. ACPSPD did not endorse VA's 1998 report to the Congress because it believed the costs were questionable and raised concerns as to the overall accuracy of the report. They noted that one facility showed more than a 100-percent increase in (or 156) individuals treated for blindness from fiscal years 1996 to 1997, with an increase of over \$2.3 million in expenditures—from \$66,000 to \$2.4 million—or 3,500 percent. VA has been unable to explain the increase in expenditures.

As VA strives to measure compliance with the requirements of section 104 of the Veterans Health Care Eligibility Reform Act, it needs to develop more comprehensive data and improve the reliability of existing information. VA acknowledges the need to improve its information systems and has several initiatives under way. We will continue to assess these efforts as we complete our study.

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Mr. Chairman, this concludes my prepared remarks. I will be happy to answer any questions you or other members of the Subcommittee may have.

<sup>6</sup>Specifically, VA developed a methodology for identifying special disability program patients from existing registries and in some instances, created new registries. Additionally, workloads were defined using diagnostic and clinical procedure codes. Program costs for specialized inpatient and outpatient care are identified using VA's Cost Distribution report.

VA'S ACCESS MEASURES FOR SPECIAL DISABILITY PROGRAMSSPINAL CORD INJURY--ACUTE CAREMeasures

Waiting time for transfer of patients to spinal cord injury center.

Goals

All patients requiring acute care receive same-day transfers to a spinal cord injury center.

Performance

In fiscal year 1996, 41 percent of VISNs met the goal; in fiscal year 1997, 91 percent met the goal.

SPINAL CORD INJURY--SEMI-URGENT CAREMeasures

Waiting time for transfer of patients requiring semi-urgent care to spinal cord injury center.

Goals

All patients requiring semi-urgent care receive transfer within 2 weeks of referral.

Performance

In period in which data was available (July 1997), 89 percent of transfers occurred within 2 weeks.

SPINAL CORD INJURY--OUTPATIENT CAREMeasures

Waiting time for an appointment for outpatient care.

Goals

All patients requiring outpatient care receive an appointment within 7 days of referral to a spinal cord injury center.

Performance

In fiscal year 1996, 87 percent of VISNs met the goal; in fiscal year 1997 all met the goal.

BLINDNESSMeasures

Waiting time for admission to VA inpatient blind rehabilitation program.

Goals

None specified.

## APPENDIX I

## APPENDIX I

Performance

In fiscal year 1997, monthly waiting times averaged 27 to 34 weeks and increased in 11 of 12 months over fiscal year 1996 waiting times.

TRAUMATIC BRAIN INJURY—INPATIENT CAREMeasures

Waiting time for admission to a designated traumatic brain injury bed.

Goals

None specified.

Performance

In fiscal year 1997, waiting times for inpatient care ranged from 1 to 5 days and improved over fiscal year 1996 performance in 12 of 14 VISNs with traumatic brain injury programs.

TRAUMATIC BRAIN INJURY—OUTPATIENT CAREMeasures

The number of days to obtain first appointment after discharge with a rehabilitation professional team member in the rehabilitation clinic.

Goals

None specified.

Performance

In fiscal year 1997, waiting times for outpatient care ranged from 1 to 14 days and improved in 8 VISNs that had outpatient programs in 1997.

AMPUTATIONS (PROSTHETICS)Measures

Percentage of prosthetic orders that are delayed; that is, not processed within 5 work days because of incomplete management or administrative action.

Goals

Delays should not be in excess of 2 percent of total orders (workload).

Performance

In fiscal year 1996, 1.3 percent of all orders were delayed; in 1997, delays were 0.7 percent of orders.

SERIOUSLY MENTALLY ILLMeasures

(1) Percentage of patients receiving outpatient visits for primary disorder within 30 days after discharge.

## APPENDIX I

## APPENDIX I

(2) The days elapsed between discharge and the first outpatient visit in the 6 months after discharge.

**Goals**

None specified.

**Performance**

(1) The percentage of seriously mentally ill patients who received outpatient care within 30 days of discharge increased from 52.1 percent in 1996 to 52.7 percent in fiscal year 1997—an increase of 0.6 percent.

(2) In fiscal year 1997, seriously mentally ill patients experienced a 2-day decrease in the number of days from discharge to the first outpatient visit.

**POST-TRAUMATIC STRESS DISORDER****Measures**

(1) Percentage of patients receiving outpatient visits for the primary disorder within 30 days after discharge.

(2) The days elapsed between discharge and the first outpatient visit in the 6 months after discharge.

**Goals**

None specified.

**Performance**

(1) The proportion of PTSD patients receiving outpatient care increased 1.6 percent in 1997.

(2) Decrease of about 2 days in the time it took from discharge to the first outpatient visit.

SELECTED OUTCOME MEASURES BY SPECIAL DISABILITY PROGRAM<sup>7</sup>

Special disability program	Description of outcome measure	Status
Spinal cord dysfunction	Patient satisfaction survey	Implemented
	Assessment of functional status	Under development
	Discharge to community living	Under development
Blindness	Patient satisfaction survey	Implemented
	Rehabilitation outcome survey	Testing instruments
Traumatic brain injury	Assessment of functional status <sup>a</sup> (percent of first-admission traumatic brain injury patients discharged from traumatic brain injury network, and acute medical rehabilitation beds to the community)	Testing instruments
Amputations	Assessment of functional status (such as percent of lower extremity amputee patients discharged from inpatient rehabilitation units to community setting)	Under development
Seriously mentally ill	Assessment of functional status (such as comparing early and late global assessment of functioning (GAF) <sup>b</sup> scores for each individual during the year or comparing FY 1997 and 1998 scores, if only one is available)	Some are implemented, others are under development; software to capture functional status data estimated to be completed by early FY 1999
PTSD	Assessment of functional status (GAF scores and data such as percent of veterans scoring equal or better in PTSD symptoms 4 months after discharge)	Some are implemented, others are under development; software to capture functional status data estimated to be completed by early FY 1999

(Table notes on next page.)

<sup>a</sup>The Uniform Data System for Medical Rehabilitation criteria separates placement outcomes into categories such as community, long-term care, return to acute facility, and other. These categories are determined through functional assessment—the percent of patients maintaining cognitive and physical functional gain at 3- and 12-month follow-up.

<sup>b</sup>GAF rates a client's overall functioning, including psychological, social, and occupational rating.

Sources: VA's Report to Congress, Maintaining Capacity to Provide for the Specialized Treatment and Rehabilitative Needs of Disabled Veterans, and several of VA's preliminary program reports on outcome measures.

<sup>7</sup>VA reports that outcome measures will also facilitate comparisons among programs and facilities from year to year to assess the progress of special disability programs in meeting goals of quality care. Two to three years will be required to fully develop and collect data for all outcome measures.

## APPENDIX III

## APPENDIX III

**REDUCTIONS IN THE FISCAL YEAR 1996 BASELINE EXPENDITURE DATA FOR VA  
SPECIALIZED SERVICES**

<b>Special disability program</b>	<b>Baseline used in May 1997 report (millions)</b>	<b>Baseline used in May 1998 report (millions)</b>	<b>Actual differences in baseline (percentage differences)</b>
Spinal cord dysfunction	\$211.2	\$199.8	\$11.4 (5)
Blindness	48.0	43.9	4.1 (9)
Traumatic brain injury	4.0	3.7	0.3 (8)
Amputation	11.8	6.0	5.8 (49)
Seriously mentally ill	2,136.7	2,080.2	56.5 (3)
Substance abuse	597.3	575.9	21.4 (4)
Homeless	79.1	75.0	4.1 (5)
PTSD (seriously mentally ill only)	100.8	99.7	1.1 (1)
PTSD	103.0	101.9	2.0 (2)

Source: VA Report to Congress, Maintaining Capacity to Provide for the Specialized Treatment and Rehabilitative Needs of Disabled Veterans.

(406149)

Testimony of Richard A. McCormick, Ph.D., on Behalf of the Committee on Care of Severely Chronically Mentally Ill Veterans, before the U. S. House of Representatives, Committee on Veterans Affairs, Subcommittee on Health, July 23<sup>rd</sup>, 1998.

Public Law 104-262, the Veterans Eligibility Reform Act of 1996 established the Committee on the Care of Severely Chronically Mentally Ill Veterans and requires the Committee to monitor the care of seriously mentally ill veterans throughout VHA. The Committee on Care of Severely Chronically Mentally Ill Veterans is broadly concerned with trends in VA's capacity to provide care for seriously mentally ill veterans. For the purpose of its work the Committee defined the pertinent population of seriously mentally ill veterans as:

Veterans who currently or any time during the past year, 1) have a diagnosed mental, behavioral or emotional disorder of sufficient duration to meet the Diagnostic and Statistical Manual of Mental Disorders (Fourth Edition) criteria that 2) results in a disability i.e., a functional impairment that substantially interferes with or limits one or more major life activities. This definition would include adults who would have met these criteria during the year without the benefit of treatment or support services.

The above definition corresponds to the one contained in the Federal Register, Vol. 58, No. 96 of May 20, 1993. A variety of federal agencies (e.g. Public Health Service, National Institute of Mental Health) drafted this definition, thus the Committee's definition is consistent with the national consensus. This definition also forms the basis for large national epidemiological studies.

The Public Health Service estimated that 6.4% of the adult population meet this definition. Extrapolating this prevalence rate to the veterans population, approximately 1,739,754 veterans meet the definition. It is estimated that approximately 296,842 disabled seriously mentally ill veterans use VHA service in a given year.

On the advice of the Committee, VHA has also adopted this as the working definition for the seriously mentally ill referred to in Public Law 104-262, Section 104. The Committee has reviewed the report of the Secretary of Veterans Affairs on Maintaining Capacity to Provide for the Specialized Treatment and Rehabilitative Needs of Disabled Veterans. The report to Congress monitors, among other special populations, the care of veterans with serious mental illness and Post Traumatic Stress Disorder. Homeless veterans and veterans with substance abuse disorders are included within the category of serious mental illness. It is most appropriate that VHA provide special emphasis to the care of veterans with serious mental illness and Post Traumatic Stress Disorder. Psychosis and Major Affective Disorders are seriously disabling conditions that are among the most common disabling conditions adjudicated to be related to veterans' time in service. Combat related Post Traumatic Stress Disorder goes to the very core of the primary mission of VHA, to care for veterans who have sustained injury and disability while serving and protecting their country.

While for the sake of reporting, these various mental disorders are presented separately, it must be noted that such separation is quite arbitrary. As many as 60% of veterans with combat related post traumatic stress disorder also abuse substances. The abuse of substances is a common avoidance reaction for veterans attempting to cope on their own with the aftermath of severe combat related trauma. Similarly detailed assessments of veterans presenting for substance abuse disorders often uncover previously undetected trauma disorders. Increasing numbers of psychotic and affective disorder patients are diagnosed with concomitant substance abuse disorders, again often related to ill-advised attempts to self medicate for the severe symptomatology associated with these disorders. Homelessness for veterans of the armed services is closely related to the presence of a mental disorder. It has been estimated that between 150,000 and 200,000 veterans are living in shelters or on the streets in American cities.

Homelessness impacts the overall care of veterans, particularly the care of seriously mentally ill veterans. A recent survey of over 17,000 veterans hospitalized in VHA facilities found that rates of homelessness varied from a high of 47.2% for those in

substance abuse treatment, to 24.3% for those being treated in general psychiatric units, and 4.7% of those being treated in medical and surgical beds.

The country, and its representatives in the Congress, have much to be proud of in its response to the needs of veterans with serious mental illness and post traumatic stress disorder. In the past fifteen years, with the urging and over-site of Congress, VHA has expanded its treatment capacity for veterans with Post Traumatic Stress Disorder, substance abuse and accompanying homelessness. VHA has also begun the difficult and potentially perilous process of moving the venue of treatment for the most seriously mentally ill from institutional to community based care. VHA clinical, educational and research programs in all these areas are internationally acknowledged. VA's contributions to the knowledge base, particularly for Post Traumatic Stress Disorder and substance abuse have been unparalleled.

This is a tumultuous time in health care. The search for healthcare value, which appropriately balances quality of care with efficiency, is driving changes in care delivery systems. VHA, under the leadership of Dr. Kizer, has articulated a strategy for increasing health care value, while remaining focused on the core missions that VHA must fulfill for our veterans. Services for the seriously mentally ill are at risk during such times of change. These patients have disorders which are complex, disabling and chronic in nature. They adversely affect all aspects of functioning. They require an integrated package of treatment and rehabilitation services which often goes beyond the scope of more narrowly defined private health plans, that are largely designed to address the needs of a higher functioning patient group, and only for the management of the more acute portion of the treatment continuum. It is critical that VHA not lose site of its commitment to providing a full continuum of care for seriously mentally ill veterans, even while VHA attempts to reshape and improve the overall value of healthcare provided for veterans.

In pursuing its charge to monitor the care of seriously mentally ill veterans throughout VHA, the VHA Committee on the Care of Severely Chronically Mentally Ill Veterans has engaged the active participation of major stakeholders in accomplishing this task. This includes national representatives from Veterans Service Organizations (Paralyzed Veterans of America, the American Legion, Vietnam Veterans of America, Disabled American Veterans), and national mental health organizations (National Alliance for the Mentally Ill, National Mental Health Association, and Substance Abuse and Mental Health Administration). The Committee offers the following specific observations on the report to Congress on Maintaining Capacity to Provide for the Specialized Treatment and Rehabilitative Needs of Disabled Veterans.

The report operationally defines capacity as the number of unique seriously mentally ill veterans treated for their disabling condition and the total dollars expended for their care. Access is narrowly defined in terms of timeliness of access to outpatient services following a hospitalization. The selection of these operational definitions was constrained by availability of national data on seriously mentally ill veterans in the centralized VHA administrative data bases. It must be recognized that the currently available data is inadequate to comprehensively and reliably monitor VHA's efforts to maintain capacity for these disabling conditions. VHA is attempting to move towards the addition of patient specific functional measures, which would add an important dimension to the data base. Progress has been made in this regard for the mentally ill. This includes the system-wide mandate to use the Addiction Severity Index, a VA research program developed, widely utilized functional assessment tool, for all patients with a substance abuse diagnosis, and the General Assessment of Functioning, a short functional assessment tool for all general mental health patients. Nevertheless, these new data elements will not be sufficiently mature to use in analyses of 1998 performance.

The data presented in the 1997 report show a national increase of 1% in the number of veterans with serious mental illness, in general, and post traumatic stress disorder as compared to 1996 levels. It must be noted that the report does not include the appropriate denominator of the total number of veterans provided service in those two years. From 1996 to 1997 there was a 3.8% increase in all veterans served, a rate far greater than the changes for seriously mentally ill or post traumatic stress disorder. From 1996 to 1997 the total number of veterans receiving some mental health service did increase at a rate of

4.8%. The seriously mentally ill are a subset of this larger group of patients. The capacity report shows that the number of seriously mentally ill substance abusers receiving VHA care actually dropped by 2% from 1996 to 1997.

This relative slower growth, or decline in the case of substance abusers, in the number of seriously mentally ill and post traumatic disorder patients cannot be simply attributed to lack of opportunity to provide care to seriously mentally ill veterans. If we consider the VA's highest congressionally mandated priority, veterans who are service connected for a mental disorder, in 1997 VHA provided at least some care to only 38.6% (175,613) of these service connected patients. Rates are higher for the subset who are service connected for psychosis (48.9% utilization) and post traumatic stress disorder (61.7% utilization), but even for these higher use groups there are large numbers of seriously mentally ill veterans not being treated in VHA. An analysis of the utilization rates by VHA Networks, shows significant variability in the utilization of VHA services by veterans service connected for a mental disorder (32% to 42%). Only 8% of the total of low income and service connected veterans used VHA mental health services nationally. Furthermore a fine-grained analysis of utilization rates by county, conducted by the Committee in two sample Networks, indicates that rates within a Network vary widely, largely related to the distance the veteran lives from a VHA access point.

The capacity report shows a decline in the expenditures on the care of seriously mentally ill veterans of 3% and for post traumatic stress disorder of 7%. Expenditures for seriously mentally ill substance abusers actually declined by 20%. This decline must be compared to a 5% overall increase in funding for VHA services during the same period of time. These decreased expenditures are in all cases the result of decreases in inpatient care. This is reflected in a 1561 reduction (28.9%) in the number of seriously mentally ill veterans who had an inpatient length of stay greater than 100 days in 1997 as compared to 1996. This decrease in inpatient care reflects the efforts of VHA to deinstitutionalize chronically mentally ill hospitalized patients. The number of substance abuse patients receiving an inpatient stay declined by 37%. This decline reflects the closure of many inpatient substance abuse treatment units.

The Committee is supportive of both the deinstitutionalization of chronically mentally ill patients and the movement towards increased reliance on intensive outpatient and residential treatment approaches to the treatment of substance abuse. If accomplished appropriately, such efforts can increase the value of mental health services. The available data, however, cause grave concern as to whether such a transition is being effectively managed throughout VHA. While the appropriate community management of formerly institutionalized chronically, seriously mentally ill patients does require the commitment of significant resources, a number of studies, including a large multi-site VHA research study, show that such care is appreciably less expensive than inpatient institutional care. Likewise, even intensive outpatient substance abuse treatment with residential care when appropriate, is significantly less expensive than inpatient care. Consequently, it would be expected that the transition from inpatient delivery systems would result in the ability to treat significantly larger numbers of the current, high priority seriously mentally ill non-users of VHA services. The national data clearly establish that the reduction in inpatient care has resulted in a reduction of funds expended, but has not resulted in any increased penetration into the unmet demand for services among the seriously mentally ill.

Of equal concern to the Committee, is the large variation among Networks on measures of capacity for the seriously mentally ill. This variation is most evident in the access measures in the report, which are in fact measures of the continuity of care provided to previously hospitalized patients. Measuring the use of outpatient services following an inpatient discharge for mentally ill patients is consistent with the non-VA sector. This is a commonly used measure for the continuity and quality of care provided for the mentally ill. For example, it is a National Committee for Quality Assurance (HEDIS 3.0) measure for some mental health sub-populations. The regional differences in the change, from 1996 to 1997, in the continuity of care provided to the seriously mentally ill varied from +11.3% to -6.1%. The change in the continuity for substance abuse treatment varied even more, from +16.0% to -15.8% across networks. The two networks with the largest decremental performance in continuity for substance abuse treatment also showed drops in the number of patients served and the dollars expended. The homeless subset of the

seriously mentally ill showed even larger variations in continuity of care (+22% to -26%) across networks.

Finally the Committee is concerned with data that is not included in the current capacity report. Existing administrative data bases do not indicate whether an adequate array of services are in place to successfully reintegrate seriously mentally ill patients into the community. The rapid deinstitutionalization of seriously mentally ill veterans needs to be accompanied by the development and deployment of community based services. A substantial body of literature, including controlled trials, establishes the efficacy of community support interventions for maintaining the seriously mentally ill patient outside of an institutional setting. These interventions mobilize the resources necessary for the patient to function in the community, assure that the patient stays connected to these resources, and help patients to function effectively in the community. Assertive case management is the core of treatment. The case manager works intensively with the patient to build, restore or strengthen support systems, assists in meeting basic human needs, and provides assistance in securing supportive housing. Through a number of randomized trials and non-experimental clinical trials, research supports the conclusion that such programs produce positive results. These results include reduced use of psychiatric inpatient services, increased use of non-hospital based services, greater independence in living and residential stability, increased patient satisfaction, and in some cases, lower treatment costs.

In FY 1997, there were 44 intensive community case management programs in VHA, largely funded from mental health expansion funds distributed following Congressional hearings held in 1993. These hearings highlighted VHA's lack of community-based programming for the seriously mentally ill veteran. Last year the Committee commissioned a study of the current status of intensive community case management programs throughout VHA. Despite the accelerated deinstitutionalization of seriously mentally ill veterans, there had been little growth in the number of these programs in VHA. Over two-thirds of VHA facilities still do not have community case management services for the seriously mentally ill veteran, including more than twenty of the largest metropolitan areas in the country. As with other measures there was marked variability across the VHA system in the existence of such clinical programming.

VHA has begun the development of an array of community based outpatient clinics. These clinics provide access points for veterans who live in areas not previously serviced by VHA. Most of these clinics are targeted for geographic areas where the utilization of VHA services by service connected and high priority eligible seriously mentally ill veterans is low. As of January 1998, 144 community based outpatient clinics had been approved by Congress. Less than 40% of the clinics implemented or approved for implementation included basic mental health services. These clinics afford an ideal opportunity for VHA to maintain its traditional commitment to the care of the seriously mentally ill by utilizing a portion of the funds being saved through inpatient reductions to provide outpatient care for seriously mental ill veterans near to where they reside. The Committee is concerned that so few of these clinics are to include mental health services for the seriously mentally ill or for patients with post traumatic stress disorder. In late 1997 VHA policy was amended to require an assessment of the appropriateness of providing mental health services at all new community based outpatient clinics. Hopefully this will result in wider access to VHA services for the seriously mentally ill.

Adequately tracking the impact of Eligibility Reform Legislation on the VHA's commitment to the care of seriously mentally ill veterans and veterans with post traumatic stress disorder require much more sophisticated and comprehensive data than is available in the current report to Congress. The deinstitutionalization of the seriously mentally ill, and other major shifts in mental health delivery systems are complex, multivariate phenomenon. Information on the availability of interventions with demonstrable effectiveness, on the retention in ongoing community treatment of veterans with serious mental illness who are deinstitutionalized, and on the functional and symptomatic outcomes for patients are critical to a full assessment of the impact of the changes underway in VHA. The Committee relies heavily upon VHA's national mental health evaluation centers (the Northeast Program Evaluation Center, the Program Evaluation and Resource Center, the National Center for Post Traumatic Stress Disorder,

and the Serious Mental Illness Treatment, Evaluation and Research Center) to extract the maximum amount of data from the current VA data bases, and to conduct focused studies to further develop critical data elements. The Committee applauds the recent establishment of Mental Illness Research Education and Clinical Care Centers, which will provide additional data on the care of the seriously mentally ill in VHA. The Undersecretary for Health has recently launched the Quality Enhancement Research Initiative (QUERI), which will focus on ten priority disease states including both psychosis/major depression and substance abuse. The two QUERI centers for mental disorders have both targeted improving the quality of outcome data on these patients, and making such data widely available, as an important priority. Hopefully the coordination and convergence of these data collection efforts will provide the data necessary to more adequately assess the status of the seriously mentally ill veteran in years to come.

**VA Federal Advisory  
Committee on  
Prosthetics and Special-  
Disabilities Programs**

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**TESTIMONY BEFORE THE HOUSE COMMITTEE ON VETERANS' AFFAIRS**

**SUBCOMMITTEE ON HEALTH**

**OVERSIGHT HEARING**

**BY  
THOMAS H. MILLER**

**CHAIRMAN,  
VA FEDERAL ADVISORY COMMITTEE  
ON  
PROSTHETICS AND SPECIAL DISABILITIES PROGRAMS**

**JULY 23, 1998**

Mr. Chairman and members of the Subcommittee, I want to express my appreciation for the opportunity to appear before you this morning to testify on behalf of the Secretary's Advisory Committee on Prosthetics and Special Disabilities Programs. We commend you, Mr. Chairman, for conducting this important Oversight Hearing on these extraordinarily important programs for our nation's severely disabled veterans.

Before discussing the current oversight hearing today, I believe it necessary to recount the status of the delivery of Prosthetic Services and the circumstances that lead to an oversight hearing conducted by the Senate Committee on Veterans Affairs on June 7, 1990. Veterans around the nation were experiencing extreme difficulty in receiving essential prosthetic services necessary to maximize independent functioning in a timely manner. Additionally, the VA Rehabilitation Research and Development Service (RR&D) was also experiencing acute managerial problems resulting in a very dysfunctional service. The Senate Committee, after a special investigation by a staff member from the General Accounting Office (GAO) scheduled the Oversight Hearing mentioned above.

During the course of the Hearing, they identified many problems that contributed to the long delays in providing timely high quality service to disabled veterans both in prosthetic services and within the special disability programs as well. The Deputy Secretary of the Department of Veterans Affairs (VA), Mr. Anthony Principi was the lead witness for the VA and all the relevant program directors accompanied him.

The Hearing revealed, what veterans already knew. An unconscionable waiting time existed to receive prosthetic services. Often they were denying these services altogether because of a reported lack of sufficient funds. It became clear funds that VA Central Office (VACO) was allocating to the local facilities were being used for purposes other than providing prosthetic services. Additionally, Prosthetic and Sensory Aids Services (PSAS) program officials within VACO were not able to track funds allocated to the local facilities because of lack of appropriate staffing and technology.

Directors of the special disabilities programs also testified regarding the negative impact the long delays in delivery of prosthetic services were having on their programs. Further, several program directors reported on very long waiting times for admission to their programs. For example, Blind Rehabilitation Service (BRS) reported that several Blind Rehabilitation Centers (BRC) around the country, required that veterans wait up to two years for admission to the program. Contributing to these long delays was lack of staffing and insufficient facilities to manage the demand for service.

Mr. Chairman, the Oversight Hearing resulted in dramatic changes in delivery of these essential services. Funding for prosthetic became centralized. A significant number of new prosthetic representative positions were added across the system. The Advisory Committee was chartered and tasked with reviewing these special programs and making recommendations to the Secretary of VA and Congress to insure the provision of high quality timely services to our nation's severely disabled veterans. Another benefit resulting from the Hearing was the provision of necessary resources enabling the other special disability programs to operate at optimum levels reducing the unconscionable backlogs for service.

With that background in mind, Mr. Chairman, the Advisory Committee held its first meeting seven years ago this month. I have the privilege of representing the Blinded Veterans Association (BVA) on the Committee since its inception and have served as its Chairman for past year and one half. The Disabled American Veterans (DAV) and the Paralyzed Veterans of America (PVA) are also permanent members of the Advisory Committee. Many distinguished Americans from a wide variety of professional disciplines have served on the Advisory Committee. All of the members possessed the professional knowledge, expertise and experience critical to formulating objective, thoughtful and reasoned assessments and recommendations. In almost every instance, recommendations made by the Committee in the first few years were accepted by VA management and implemented swiftly. Dramatic improvements were observed almost immediately. Outcry from disabled veterans regarding frustrations with the inability to receive prosthetic services in a timely manner diminished with the implementation of Centralized Funding of Prosthetics. Significant improvements were also noted in access to the other special disabilities programs. The Advisory Committee meets twice yearly and during each meeting receives reports from the special program officials. Some recurring themes have persisted throughout the life of the committee and are deserving of mention here. Since its inception, centralized funding was targeted for change. Managers in the field resented losing those dollars and their discretion to use them for whatever priority they believed to be most important. Throughout the past seven years, the Committee has strongly supported centralized funding for Prosthetics. We continue to believe it is the most effective means for providing timely, high quality prosthetic services.

With the implementation of Dr. Kizer's "Vision for Change" and the reorganization of the VA Health Care system into 22 Veterans Integrated Service Networks (VISN), the decision was made to decentralize prosthetic funding to the Network level. From there the prosthetic dollars would be allocated to the local facility level based on whatever formula the Network feels appropriate. During the past year, the Committee has received reports that due to insufficient funding levels, serious problems for the delivery of prosthetic services were on the horizon. In the second quarter of this Fiscal Year, the delayed order report submitted to PSAS in VAHQ revealed over 8,300 delayed orders. Further it is anticipated these delays will increase in the third and particularly the fourth quarter. The reason given is that in an effort to minimize delays, prosthetic services at the local level have been borrowing against their next quarter allocation so as not to run out of funds. Now that they are in the fourth quarter with no future quarter to borrow against, serious shortfalls are projected. Dr. Kizer advises VSO leaders that a cash reserve exists in VAHQ. Network directors have repeatedly been advised that should they need emergency funding for whatever purpose they should request such assistance from VAHQ. He has indicated that no such request has come forward because of funding shortfalls in Prosthetics.

Given this scenario, the Committee has serious concerns regarding how well the Network allocation methodology is working and the degree to which effective communication exists between the facilities, Networks and VAHQ. Three VSO members of the Committee, including myself, had the opportunity recently to meet with many of the Prosthetic Representatives during their National Training Seminar with Spinal Cord Injury (SCI) program clinicians. Please see the attached letter I forwarded to Dr. Kizer regarding our findings and concerns.

Based on alarming information received during the Prosthetic Representative meeting, it appears that Prosthetics Service is revisiting the past as a result of the decentralization of funding. While funding was considered to be an important issue, many of the Representatives believe the most critical issue is staffing. They argued they just did not have sufficient staffing to manage the increasing workload they are all confronted with. Further contributing to this problem has been the reorganization and realignment that has taken place in the field. Either the Prosthetic Services have been eliminated altogether with the functions reassigned to Acquisition Service or they have experienced reductions in the numbers of Purchasing Agents assigned to PSAS. In some cases, the Prosthetic Representative or Chief position has been eliminated or when a vacancy has developed it is filled with an individual who has no professional credentials to fill the position. All Chiefs reported significant increases in workload resulting from passage of the Eligibility Reform Act. Unfortunately they have not received proportional increases in staff to manage this increasing workload. Even more disturbing were allegations that some chiefs were told they were not to report delayed orders nor to indicate that funding was a problem. Even more disturbing is that a few chiefs reported that delayed order reports they had submitted to management were altered to reflect fewer delayed orders. The implication being that facility directors were afraid to report delays or funding shortfalls for fear of being marked down as not meeting their performance standards. Consequently, if Network Directors are not receiving the appropriate reports indicating the need for additional funding, they will not make such requests from VAHQ. This also raises questions as to whether similar behavior could be occurring at the Network level, that is Network Directors are not making requests for additional funding for fear of criticism for not being good managers.

Mr. Chairman, if reports are being falsified or not being submitted at whatever level of the organization, it must be stopped immediately. Behavior such as this cannot be tolerated. It must also be noted here the perception of those of us who had the opportunity to meet with the Prosthetic Chiefs was one of extremely low morale. Extremely low morale was attributed to sheer frustration in not being able to provide the high quality prosthetic services essential to disabled veterans. Further they believe their professional expertise is being ignored or discounted in favor of reducing the cost of providing services.

The revisitation of past problems can be seen in the reorganization and restructuring of PSAS in the field as well as in Headquarters. One of the single most important outcomes of the Oversight Hearing was the provision of many new Prosthetic Chief positions in the field. That action resulted in more efficient and professional delivery of clinical services to our nation's disabled veterans. Staffing levels in Headquarters were also increased facilitating more effective monitoring of activities in the field as well as completing a mandated number of site visits each year. Latest trends in the field are to dismantle PSAS reassigning many or all of their function to the Office of Acquisition and Material Management with an apparent disregard for the professional skill, knowledge and expertise possessed by these representatives and their staff and necessary for the positions. At one facility, San Francisco VAMC, the entire PSAS staff from the assistant chief down were realigned under Acquisition. The chief was given a new title and has no involvement with Prosthetics whatsoever. This is a man with 25 years experience in Prosthetics.

Another management decision that has negatively impacted PSAS as well as some of the other special disabilities programs in the field was the decentralization of many personnel functions, particularly hiring. The Committee has learned that when vacancies developed, such as the Chief, the positions are only announced locally, if at all. This prevents any opportunity for others around the system to apply. This is an unfortunate practice, especially in prosthetics given PSAS has a national prosthetic representative training program. Similarly, Assistant Chiefs within the system with valuable experience, will not be able to apply for these vacancies. If these trainees do not have an opportunity to apply for vacancies there seems to be little point in the training program. The objective should be to employ the most highly qualified individuals to fill these vital positions. Similar shifting of programmatic functions has been experienced within the BRS, specifically Visual Impairment Services Team (VIST) coordinator positions. These positions have been reduced from full time to part time with the duties being reassigned to an existing staff social worker. This has occurred at three facilities, two in one Network. Following intervention from Deputy Secretary Gober, one changed its decision and has filled the position on a full time basis.

Turning to the staffing of PSAS within VAHQ, Mr. Chairman, the staffing has been decimated by either reassignments, buy-outs or retirements. None of these positions have been approved to be filled. The service is left with only two highly qualified prosthetic managers. They no longer can conduct site visits as mandated by the Oversight Hearing of eight years ago and can barely monitor prosthetic activities in the field electronically. On the positive side, the Service has been successful in developing a very powerful electronic system to capture important data regarding the type of prosthetic device prescribed, its cost and the timeliness of delivery. Unfortunately however, their ability to use this tool is being compromised for lack of qualified staff. Given these scenarios, our Committee questions whether the decisions made in the field are driven more by cost savings rather than quality.

The Advisory Committee is pleased with the substantial improvements in the RR&D program throughout the past seven years. Although there was a significant delay in filling the vacancy created in the Director's position with the retirement of Dr. John Goldschmidt a year ago, there appears to be a genuine commitment on the part of the Chief Research and Development Officer. He has pledged not only to protect but to expand the program. Two additional Centers of Excellence have been established without new funding. Research and Development activities seem to be progressing in a variety of relevant areas. The Committee has expressed serious concern over the years about proposals to organizationally realign the RR&D Service under the Research & Development Service. Our concern centers around the fear that RR&D dollars would be swallowed up by medical research priorities leaving little for RR&D projects. This actually occurred in the past giving the committee pause each time the proposal surfaced. The Headquarters reorganization implemented by Dr. Kizer has accomplished that realignment and thus far appears to be working without negative impact on RR&D. It clearly requires a close monitoring, should personalities or priorities change.

Mr. Chairman, the reorganization of the Veterans Health Administration (VHA) into 22 VISNs has raised some concerns for our Committee regarding the potential this organizational structure presents for the Special Disabilities Programs to lose their identity as national programs.

Programs such as Blind Rehab and Spinal Cord Injury are high cost programs and therefore seem to attract the attention of the budgeteers and number crunchers as the most likely targets for cost savings. Consequently, staffing standard guidelines and models of service delivery are being challenged. Decisions are being made without the critical input of the program Subject Matter Experts. Contrary to Dr. Kizer's guidance, programmatic decisions being made in the field are being made in the absence of consultation with program officials in Headquarters. Bed days of care seems to be the over riding concern for these local officials regardless of the impact on quality of care. PVA reports its findings that significant numbers of SCI FTEE positions have been eliminated thus reducing VA capacity to delivery SCI Services. BRS reports that in at least two facilities staffing reductions have resulted in the inability to operate all authorized beds. In another facility, a proposal has been submitted to close 15 beds. In all these cases, it would appear VA is violating the legislative mandate to maintain it capacity in providing rehabilitative services to disabled veterans. In fact, Mr. Chairman, our committee refused to endorse the Capacity Report submitted to your Committee earlier this year. The committee believed the data was flawed and conflicted with the data possessed by the individual programs contained in the report. It appears that the differences in which these programs are being organizationally aligned across the system is presenting some problems with regards to data collection. VHA seems to be moving in the right direction in terms of developing and implementing the state of the art technology providing the ability to collect accurate data. The Advisory Committee is not confident they have reached their objective of rolling up accurate reliable national data.

This is critical given Dr. Kizer's desire to have all management decisions be data driven. Mr. Chairman, as you know, the ERA requires the VA to consult with our Committee during the implementation phase of the Eligibility Reform Act. VHA has consulted with us as they attempted to define the terms utilized in the legislative language such as capacity, enrollment and uniform benefits package. They have also met with us during our scheduled meetings to brief the Committee regarding the status of the Capacity Report to be submitted to Congress. Our Committee consulted primarily with the working group of the Steering Committee appointed by Dr. Kizer charged with developing recommendations to the Under Secretary regarding the definition of capacity. Included in those discussions were the definition of resources as they applied to capacity. Initially, there were significant differences between the working group and our committee. The working group did not believe the number of beds or FTEE should be included in any definition of resources. They believed dollars should be the only criteria. As with the overall transition from inpatient acute care to outpatient managed primary care, the members of the working group seem to feel cost savings realized by providing service on an outpatient basis is more important than the outcomes derived from inpatient or residential programs. Ultimately, the recommendation was made to Dr. Kizer to include a definition of resources that contained dollars, beds and FTEE. The only caveat however, was that beginning October 1, 1998 that definition would change to include only the number of unique veterans served and outcome measures.

Each of the special programs are in the process of developing outcome measurement data collection instruments. They have not yet had sufficient time to test, refine and validate these instruments. Until this process has been completed, the Committee has strongly recommended any change IN THE DEFINITION OF RESOURCES BE DELAYED. We believe this

recommendation will be implemented but it does not appear the programs in the field are yet aware of the change.

Other programs that have been dramatically impacted by the Eligibility Reform Act legislation and organizational realignment in the field of Optometry as well as Audiology and Speech Pathology services. Each of these fields have experienced significant increases in work loads without any appreciable increase in staffing to help respond to the workload. Here again, there is little uniformity or consistency across the system, making it more difficult for program managers in Headquarters to monitor their programs. Audiology and Speech Pathology are splitting in many local facilities or Networks further complicating monitoring by Headquarters. Both of these services place an increasing workload and funding pressures on Prosthetic Service.

The restructuring of the special disabilities programs in the field continues to present problems for these programs. While it may be beneficial to reconfigure the organizational structure as VHA transitions to a Managed Primary Care Model of health care delivery, it is not clear how these special programs fit into this model. Most of these programs are unique to VA. If not unique than VA is the premier provider of these services and comparable services are not readily available in the community. In the past, these services reported directly to the medical center Chief of Staff or the facility director. Now in many instances they report to product line managers or some other layer of management further from the key decision makers at the facility. The logic of how some of the programs are assigned to a particular product line also makes little sense in terms of service delivery. While the Under Secretary for Health and all his top management officials verbalize strong support for the special disabilities programs, this is not always reflected in decisions being made in the field. It is certainly plausible, given the magnitude of the changes taking place in VHA, but there is a lack of communication between various elements of the organization. Critical decisions impacting special programs should not be made in a vacuum or to satisfy one lower level management team.

The final area that causes the Committee great concern is that of national education and training programs. In the past an element of VHA known as the Rehabilitation Education Program (REP) coordinated and funded all aspects of national training programs. Now the REP has been consolidated into a new organizational entity known as the Employee Education Program. This new entity continues with the coordination and planning functions but the travel dollars that allow employees to travel to these programs is now decentralized to the Network and local level. Each program director in VAHQ is very worried that sufficient travel dollars will not be available which prevents their employees from attending critical education and training programs. The recent training program conducted by PSAS and SCI may provide some indications as to how well this new process works. A number of Prosthetic Representatives were unable to attend for lack of travel dollars at their facilities. Others could not attend because their work loads did not permit. If they take a week off to attend the training, they would fall hopelessly behind resulting in delayed orders. Granted it may be too early to make critical judgement regarding the new organization and process for carrying out education and training within VA, but it certainly bares close monitoring.

Mr. Chairman, the changes that have occurred in VHA have been truly profound and there is no question all that Dr. Kizer envisioned has not yet been accomplished. Further there is no question that modern methods of practicing medicine dictate the changes currently being implemented. These changes are driven by constrained budgets and flat lined appropriations. The fundamental question for this Committee is how to integrate these very special programs and services provided by VA that may not lend themselves to the ambulatory model of service delivery. If there are more cost efficient models for service delivery, they do not appear to be on the immediate horizon. Consequently, decisions regarding programmatic changes must be made in consultation with Headquarters program officials. Further substantial changes in delivery models should not be made until alternative models have been tested and determined by outcome data to produce the same high quality outcomes the current models are achieving.

Thank you Mr. Chairman, that concludes my testimony. I will be pleased to answer any questions you might have.

**VA Federal Advisory  
Committee on  
Prosthetics and Special-  
Disabilities Programs**

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July 13, 1998

Dr. Kenneth W. Kizer  
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Dear Dr. Kizer:

As you know, I have the privilege of chairing the Advisory Committee on Prosthetics and Special Disabilities Programs, and I want to report to you on a recent field hearing held by the Committee. We learned of a national training program scheduled for Prosthetic Representatives, Physical Medicine and Rehabilitation, and Spinal Cord Injury, (SCI) treatment teams during the week of June 22, 1998 in Orlando, Florida. The Committee believed this would provide an excellent opportunity to meet with Prosthetic Representatives to obtain a status report on Prosthetic Services.

In other forums, Veterans Service Organizations representatives, (VSOs), to the Advisory Committee have reported anecdotal information suggesting serious funding problems exist in the field, as manifested by a dramatic increase in the number of delayed orders in the second quarter of FY1998. Unfortunately, either the lack of funding or scheduling did not permit other members of the Committee to attend this national training program. In addition to myself however, Mr. Jerry Steelman from the Disabled American Veterans, (DAV), and Mr. Rick Glodfelty of the Paralyzed Veterans of America, (PVA), were able to attend the field hearing.

Dr. Kizer, we want to make you and your senior management staff aware of a number of important issues that surfaced during the field hearing:

1. While there was a clear consensus that serious funding shortfalls were a problem, this was not the most important issue for these prosthetic representatives. Most indicated they have been forced to borrow against the following quarter in order to provide timely prosthetic services. After June 30, 1998 however, there will be no quarter to borrow from and this raises serious concerns. Nearly all have been told they are not to have delayed orders and will find themselves against the wall in terms of funding in the last quarter.

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2. The most significant issue for the vast majority of those prosthetic representatives present was the lack of sufficient staff to manage efficiently the current work load. During a period where Eligibility Reform has caused a dramatic increase in their work loads (by 25 to 30 per cent), most have experienced staffing reductions or restructuring that have negatively impacted their ability to process prosthetic orders in a timely manner. Many Prosthetic Representatives indicated substantial overtime was absolutely required in an effort to manage the existing work load and not have to report delayed orders. Not all representatives could obtain approval to pay overtime and nearly all relied heavily on volunteers, work study students, compensated work therapy and others to try and process orders and prevent backlogs. These same representatives also reported many volunteer hours from their staff, coming in early and staying late attempting to provide timely service.

3. Restructuring into product lines or other organizational realignments have resulted in PSAS nearly being eliminated in some cases. In those cases, responsibilities transferred to Supply Service. Often Prosthetic PA positions have been eliminated with their functions being assumed by Supply. At one station, all the PAs as well as the Assistant Chief were reassigned to Supply while the Chief was given a new title, Marketing Manager with virtually no involvement with Prosthetics. This individual has 25 years experience in Prosthetics but Medical Center management has chosen not to take advantage of his years of professional knowledge, expertise and experience in this critical clinical discipline.

Prior to being realigned into product lines, Prosthetic Representatives had direct contact with the Facility Director at least annually when management briefings were conducted. Since being reorganized, these representatives find additional layers of management between themselves and the Medical Center Director and in most cases no longer have management briefings and direct access to the Director this opportunity afforded them.

4. A number of Prosthetic Representatives were unable to attend this important national training program. Two principal reasons were given: (1) they were told travel funds were not available for them to attend and, (2) representatives were so short staffed they felt they could not take a week from their services for fear of falling behind causing delayed orders. They were especially concerned they would receive disciplinary action should they have delayed orders.

It is important to note here that at least 25% of those attending the program have been told they are not to report delays even if they exist. Some in attendance were not willing to speak up for fear of recrimination upon returning to their station. Some reported that delayed order reports they had prepared were altered by their superiors prior to being forwarded to Prosthetic & Sensory Aids (SHG) Service at VAHQ.

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5. The inability for some Prosthetic Representatives not to attend the training program for lack of travel funds raises questions regarding the decentralization of travel funds for such education and training programs. In prior meetings the Committee has expressed concerns over the elimination of the Rehabilitation Education Program, (REP), which in the past supported these national training programs with necessary travel funds as well as other programmatic support. Apparently, competition for these funds at the local level is extremely keen and unfortunately representatives who certainly could have benefitted from this valuable training were not able to attend.

6. Another issue many prosthetic representatives were concerned about is the lack of adherence to National Standards and Guidelines for the Provision of Prosthetic Services. In their view, restructuring and organizational realignments have frustrated PSAS maintaining a national programmatic identity and consistency in service delivery.

7. Another aspect of the staffing problem and the need for adherence to National Guidelines relates to the classification of Prosthetic PAs. A few stations have been successful in reclassifying these positions from GS-5 to GS-6 which has helped in recruiting and retention of qualified PAs. Apparently, there have been a number of attempts to have these positions classified as Health Care Technicians rather than PAs. The feeling was this classification would more accurately reflect the responsibilities and duties these individuals carry out on a daily basis. They do much more than just prepare purchase orders. They attend nearly all clinics for disabled veterans and provide essential input regarding prosthetic devices and appliances.

Dr. Kizer, the Committee feels it is imperative to bring these issues to your attention at this time because of the funding implications for the remainder of the fiscal year. It seems clear to us that serious communication problems exist between the Prosthetic Representatives and their Facility Directors; the VAMC Director; and the Network Directors and between the Network Directors and Headquarters. There is good reason to believe that at least some Facility Directors are not reporting delayed orders for fear of being marked down in their performance by their respective Network Director. It may also follow that some Network Directors are fearful if they request additional funding from Headquarters that they too will be marked down on their performance. Whether these are the reasons or not, you have told the VSOs that you have not received any request for additional funds for prosthetics.

Those of us who regularly attend your briefings for the VSOs are well aware of the cash reserve maintained in Headquarters that could be used for just this purpose. You have in fact stated that to be the case, but have not been informed of any need in the field. Those of us who had the opportunity to meet with the Prosthetic Representatives felt strongly that the information we received should be shared promptly with the other

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members of our Advisory Committee. To that end, a copy of this letter will be mailed to the Committee members. We believe there is some urgency regarding resolution of at least the funding issues and the remaining issues should be carefully reviewed as soon as possible.

The Committee will continue to work with you and your staff to insure the delivery of timely high quality services to our nations disabled veterans. It is our hope that sharing our findings with you will facilitate the apparent communication problems within the new organizational structure.

Sincerely,

A handwritten signature in black ink, appearing to read "Thomas H. Miller". The signature is written in a cursive, somewhat stylized script.

Thomas H. Miller, Chairman  
VA Federal Advisory Committee  
on Prosthetics and Special  
Disabilities Programs

THM:am

**STATEMENT OF**  
**THOMAS L. GARTHWAITE, M.D.**  
**DEPUTY UNDER SECRETARY FOR HEALTH**  
**DEPARTMENT OF VETERANS AFFAIRS**  
**ON MAINTAINING CAPACITY TO PROVIDE FOR THE SPECIALIZED**  
**TREATMENT AND REHABILITATIVE NEEDS OF DISABLED VETERANS**  
**BEFORE THE SUBCOMMITTEE ON HEALTH**  
**COMMITTEE ON VETERANS' AFFAIRS**  
**U.S. HOUSE OF REPRESENTATIVES**  
**JULY 23, 1998**

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Mr. Chairman, I am pleased to be here to discuss VHA's implementation of the legislation designed to ensure that the Department maintains the scope and quality of programs providing for the specialized treatment and rehabilitative needs of disabled veterans.

VHA's programs that meet the specialized needs of veterans help define the VA as a unique healthcare system for veterans. From VA's inception, Congress has recognized our unique potential to serve as a national leader in the research and treatment of special disabilities. Due to the prevalence of certain chronic and disabling conditions among veterans, VA has developed strong expertise in certain specialized services. The VA programs and services for certain special disability groups -- veterans with Spinal Cord Dysfunction, Blindness, Traumatic Brain Injury, Amputation, Serious Mental Illness and Post Traumatic Stress Disorder -- are not widely available in the private sector. We are committed to meeting the care needs of veterans who have come to rely on VA for these specialized services.

Public Law 104-262 requires that we maintain our capacity to provide for the specialized treatment and rehabilitative needs of disabled veterans (including veterans with spinal cord dysfunction, blindness, amputations and mental illness) within distinct programs or facilities of the Department that are dedicated to the specialized needs of those veterans. The legislation requires ongoing monitoring of these special programs and requires reports to Congress. VA has submitted two reports to Congress, one in May

1997 and one in June 1998, concerning our capacity to meet these specialized needs of the veterans we serve.

**Implementation of Public Law 104-262**

We established an Eligibility Reform Steering Committee to manage implementation of the law. In addition, we established the Special Disability Programs Work Group to specifically address the requirement that we maintain capacity to provide specialized services to treat disabled veterans. The Work Group consulted with a number of stakeholders such as, National and State veterans' service organizations, distinguished physicians and universities and colleges, other veterans organizations, VHA Networks and Facilities, and Special Program Managers. We also consulted with the Federal Advisory Committee on Prosthetics and Special Disabilities Programs and the Committee on Care of Severely Chronically Mentally Ill Veterans.

VA, in consultation with its stakeholders, defined various terms identified in the law, such as the conditions for which capacity must be maintained and definitions of how to measure capacity and access to care, as follows:

- Six disabling conditions that require specialized treatment and rehabilitation are: spinal cord dysfunction, blindness, amputations, serious mental illness, Traumatic Brain Injury and Post Traumatic Stress Disorder. Homeless veterans and substance abusers, who are disabled due to mental illness, are included within the category of veterans disabled due to serious mental illness.
- Capacity is measured by the number of unique individuals with the identified conditions treated within specialized bed sections and clinics and the dollars expended for their care. For veterans disabled by blindness and spinal cord dysfunction, capacity is also measured in terms of the number of specialized beds and FTEE.
- Access is defined as timeliness.

### **Summary of Capacity Maintenance**

The principal measure of capacity is the number of veterans treated. Nationally, the number of veterans treated in the 6 programs was maintained or increased for all categories, except amputation, which declined by 2%. Greater emphasis on preserving limbs and better management of veterans at risk has resulted in fewer amputations per year. Also, reduced expenditures for amputation, SMI and PTSD reflects an increase in efficiency, as more costly hospital inpatient treatment was replaced by outpatient care or by domiciliary care. Better care management and emphasis on primary care has also increased efficiency and reduced costs. In some cases, reduced demand, rather than reduced capacity, appears responsible for apparent capacity reductions. At many facilities, there have been fewer veterans seeking care, particularly Category C veterans. Some networks also explain that specialized capacity numbers give an incomplete picture because increasing numbers of patients with these conditions are appropriately maintained in primary care and general care programs. Attachment 1 illustrates workloads and dollars spent for SMI care in specialized programs as well as overall in all programs.

VA's performance for FY 1997 compared to FY 1996 for the specialized programs is summarized as follows:

#### **Spinal Cord Dysfunction:**

- Nationally, the number of individuals treated for spinal cord dysfunction and dollars expended increased from FY 1996 to FY 1997, by 4% (patients) and 3% (dollars), respectively. The number of FTEE and operating beds decreased by 6% and 5%, respectively.
- A noted improvement in timeliness from FY 1996 was achieved in FY 1997. Acute care improved from 41% to 91%, meeting the 'timeliness for admission' standard (one day), and routine care improved from 87% to 100%, meeting the 'timeliness of appointments' standard.

#### **Blindness:**

- Nationally, the number of individuals treated for blindness and dollars expended each increased by more than 20% from FY 1996 to FY 1997. Similarly, the number of FTEE and operating beds increased by 5% and 1%, respectively.
- In FY 1997, 11 of the 12 monthly waiting times increased over those of FY 1996, in the range of 1 to 8 weeks.
- In FY 1997, up to 50% of veterans who used Blind Rehabilitation Outpatient Services did not require admission to the inpatient program. There are no comparable data for FY 1996.

**Traumatic Brain Injury:**

- Nationally, from FY 1996 to FY 1997, the number of individuals treated for traumatic brain injury and dollars expended increased by 43% and 68%, respectively.
- TBI waiting time has remained about the same as that of FY 1996, i.e., about 4 days for admission to TBI beds and about 7 days for outpatient care.

**Amputation:**

- Nationally, the number of individuals treated for amputation in FY 1997 was 98% of the FY 1996 level, while expenditures decreased by 2% from the FY 1996 level.

**Seriously Mentally Ill (SMI):**

- Nationally, the number of individuals treated for SMI increased by 1% from FY 1996 to FY 1997, while expenditures decreased by 3% from the FY 1996 level.
- In general, there was about a 1% increase in FY 1997 over FY 1996 in the proportion of veterans receiving any psychiatric outpatient care within 30 days after discharge. This increase was accompanied by a 2-day decrease in the number of days from discharge to the first outpatient visit.

**Substance Abuse (SMI Only):**

- Nationally, the number of individuals treated for substance abuse (SMI only) in FY 1997 was 98% of the FY 1996 level, while expenditures decreased by 20% from the FY 1996 level.

- There was about a 3% increase in FY 1997 over FY 1996 in the proportion of veterans receiving any substance abuse outpatient care in the 30 days after discharge.

**Homeless (SMI Only):**

- Nationally, the number of homeless (SMI only) individuals treated in FY 1997 was 100% of the FY 1996 level, while expenditures decreased by 3% from the FY 1996 level.
- In general, the accessibility of psychiatric and substance abuse outpatient services to discharged homeless veterans increased in FY 1997 over FY 1996 in both general psychiatry and substance abuse programs, by about 3% and 5%, respectively. These increases were accompanied by a reduction in the waiting time for the initial outpatient visit by about 11 days for a psychiatric outpatient visit and by about 13 days for a substance abuse outpatient visit.

**PTSD (SMI Only):**

- Nationally, the number of individuals treated for PTSD (SMI only) increased by 1% from FY 1996 to FY 1997, while expenditures decreased by 7% from the FY 1996 level.

**PTSD (All):**

- Nationally, the number of individuals treated for PTSD (all) increased by 1% from FY 1996 to FY 1997, while expenditures decreased by 6% from the FY 1996 level.
- There was about a 2% increase in FY 1997 over FY 1996 in the proportion of veterans receiving any psychiatric outpatient care in the 30 days after discharge. This was accompanied by a decrease of almost two days in the time it took from discharge to the first outpatient visit.

**Plans for the Future**

To ensure the delivery of excellent health care value, VHA is developing a system for monitoring that includes outcome measures. Outcomes are the outputs of the care process. Performance measurement in VHA is focusing on 5 domains of value that

include access, cost, quality, customer/patient satisfaction, and functional status. Outcome measures, such as satisfaction with care and functional status, shift the focus of evaluation from resources, or the inputs of care, to the outputs of the health care process. Outcome assessments, adjusted for severity of illness, provide benchmarks for goal setting and information for administrators and policy makers for use in resource allocation decisions. Outcome measures will also facilitate comparisons among programs and facilities from year to year to assess the progress of special disability programs towards meeting the goals of providing high quality, optimally delivered medical care.

Focusing on outcomes (e.g., readmission rates, complications, functional status, continuity of care) rather than on inputs, (e.g., beds occupied, dollars spent) also provides an opportunity for innovations in service delivery and enhanced patient satisfaction.

Preliminary outcome measures have been identified for each of the special disability programs, but it will take 2 to 3 years to fully develop and collect data for all outcome measures. Patients treated and expenditures will be retained to assess capacity until refined outcome measures are available. These outcome measures will be used with the capacity measures, including number of unique individuals treated, to ensure that quality is maintained and to assess whether innovative approaches are effective.

### **Conclusion**

I am pleased to report that VHA has maintained its national capacity to provide for the treatment and rehabilitation of the main classes of specially disabled veterans. While some subgroup and some network variation exists, we monitor these variations, and work towards ensuring equitable distribution of resources to provide equal access to all eligible veterans seeking care for their disabling conditions. This concludes my statement. I will be pleased to respond to your questions.

**Ratio of FY 1997 to FY 1996 for Seriously Mentally Ill Individuals Treated  
and Dollars Spent**

<u>Disability</u>	<u>Specialized Care</u>		<u>All Care</u>	
	<u>Individuals</u>	<u>Dollars</u>	<u>Individuals</u>	<u>Dollars</u>
Seriously Mentally Ill	101%	97%	102%	103%
Substance Abuse	98%	80%	97%	97%
Homeless	100%	97%	100%	100%
PTSD (SMI Only)	101%	93%	103%	104%
PTSD	101%	94%	103%	105%

Although the indicated patient categories had "Specialized Care" dollar decreases ranging from 3% to 20%, each group of patients except Substance Abuse received at least as much total ("All") care in terms of both individuals and dollars in FY 1997 as in FY 1996. Despite a considerable shift to less-expensive outpatient care, the lone exception, Substance Abuse, had only minor reductions in "All" care for both individuals treated and dollar expenditures: the FY 1997/FY 1996 ratio was 97% for both measures.

STATEMENT OF  
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ON MAINTAINING CAPACITY TO PROVIDE FOR THE SPECIALIZED  
TREATMENT AND REHABILITATIVE NEEDS OF DISABLED VETERANS  
BEFORE THE SUBCOMMITTEE ON HEALTH  
COMMITTEE ON VETERANS' AFFAIRS  
U.S. HOUSE OF REPRESENTATIVES  
JULY 23, 1998

Mr. Chairman and members of the Committee, I appreciate the opportunity to appear before you today. I look forward to discussing the VA's implementation of section 1706 of Title 38, USC and VISN 1's management of and support for these four very important Special Programs.

VISN 1, the VA New England Healthcare System, includes nine Medical Centers located in the six New England states, Vermont, New Hampshire, Maine, Connecticut, Rhode Island and Massachusetts. Most of these Medical Centers have significant, longstanding affiliations with some of the most prominent Medical Schools in the country. These include Harvard, Yale, Brown, Dartmouth, Boston University, Tufts, and others. The veteran population served spans the continuum from the densely populated, urban environment in Boston to the very rural woods and mountains of Maine, Vermont and New Hampshire. On paper there are a decreasing number of veterans in this area but the overall workload has not declined considerably in the past few years. We provide the full spectrum of healthcare services in VISN 1 including many special programs such as Spinal Cord Injury, Open Heart Surgery, two Domiciliaries, an extensive Compensated Work Therapy Program, a Blind Rehabilitation Center and a model program for addressing the needs of Homeless veterans.

The importance of the Special Programs identified by Dr. Kizer has been recognized in VISN 1 and appropriate support for these programs has been shown throughout the Network. Our Strategic Plans have been developed with the goal of ensuring that these programs will receive appropriate attention and resources to enable them to continue to operate effectively now and in the future. We have elected to move forward with the implementation of the Service Line concept, which we believe will enhance the quality and accessibility of the services we offer veterans. The Spinal Cord Injury Program and the Chronically Mentally Ill Program have both been identified as areas in which Service Lines are to be developed. As this concept evolves each Service Line will be allocated a budget and responsibility for providing the required services to our veteran population. We believe this will assist in the development of improved methods of care delivery and will make these and other programs more effective and more efficient. They will be able to provide increased high quality service to more veterans at the local level.

We believe that the implementation of the Service Line concept for these Special Programs, and for many other critical clinical and administrative services, will promote the development of an integrated healthcare system. This will help to ensure that the healthcare being provided in VISN 1 is of consistently high quality among all facilities in the Network. Specialized expertise will be further enhanced, and clinical care, research and education will be improved.

In spite of declining resources in VISN 1, we have had many substantial accomplishments in our Special Programs:

- Blind Rehabilitation – VISN 1 has maintained capacity to provide veterans a full range of blind rehabilitation services. Since October 1996, the VA Connecticut Healthcare System has staffed 45 beds at the West Haven division. This includes 37 rehabilitation beds and 8 beds dedicated to the

Computer Access Training program (CAT). Veterans are referred for inpatient rehabilitation from 11 different VISNs. The program continues to average over 300 discharges per year and maintains an approximate average daily census of 36 veterans. 100% of veterans referred to inpatient blind rehabilitation by their local VIST (Visual Impairment Services Team) Coordinators have access to the program within 6 months of receipt of their application. 100% of veterans identified who could benefit from inpatient rehabilitation are scheduled for evaluation for inpatient blind rehabilitation within 30 days. 100% of veterans currently on VIST rolls are offered an annual review. There is extensive interaction with the Blinded Veterans Association on a regular basis. They are active partners in helping us to monitor quality and their regional representatives make regular visits to the West Haven campus.

There has been a proposal to reduce the number of beds at the Blind Rehabilitation Center at West Haven. This recommendation has come from the Blind Center management and is not necessarily opposed by the Blinded Veterans Association or the Director of Blind Rehabilitation in VA Headquarters. They do not want to see a net reduction in available beds but I think they understand that the number of beds at West Haven may be too large. The space available at the West Haven campus has been an issue for several years and the size of the program (45 beds) is considered extremely large. Most programs average 30-35 beds. In the last five years there has been a declining workload experienced at West Haven and the current waiting list of approximately 150 veterans is similar to that experienced by 30-35 bed units. It is believed that if 15 beds could be relocated to another VISN, the remaining 30 beds would adequately serve the anticipated demand and would allow appropriate space for a more efficient operation. We are working closely with VA HQ and the BVA to address this issue and to ensure there is no reduction in the availability of services for blinded veterans.

- Spinal Cord Injury – The inpatient Spinal Cord Injury Program located at the Brockton/West Roxbury Divisions is a well-recognized leader in the field of spinal cord injury treatment. They receive referrals from throughout the country and provide leadership, education and guidance in spinal cord treatment for facilities throughout VISN 1. Although inpatient capacity has not changed, the number of operating beds and the staffing levels have changed over the past few years with the consolidation of two long-term care wards at the Brockton Division. However, the present capacity of Brockton and West Roxbury are more than adequate to meet current and anticipated demand. In fact, the available beds are underutilized due to several factors. A very efficient treatment team, shortened lengths of stay, increased emphasis and availability of outpatient services, and declining demand are among some of the reasons these beds are not being fully utilized. It should be noted that despite the decrease in operating beds and average daily census, eligible veterans requiring SCI inpatient care have never been denied needed care. The number of patients treated has remained about the same for the past two years and the total dollars allocated to SCI has increased.

Access to care is excellent. Same day admission for patients who require acute care is available and patients referred for a routine SCI appointment are seen within five days, which exceeds the standard of seven days. SCI coordinators are in place at each facility in VISN 1 and provide appropriate and timely patient referrals for admission or outpatient clinic follow up. Outcome measures such as the Functional Independence Measure (FIM), Deiners' Satisfaction with Life Survey (SWLS) and patient satisfaction survey have been initiated at Brockton/West Roxbury to establish a baseline from which to evaluate quality of care and patient satisfaction. Performance on Customer Service Standards as collected by the VHA National Customer Feedback Center (NCFC) placed the Brockton/West Roxbury SCI Service

number one among all VA SCI Centers in the areas of Access, Information, Emotional Support, Overall Coordination of Care and Continuity of Care. They were second in Preference and Courtesy and third in Visit Coordination. In addition, the VISN has funded staff training and has established a Steering Committee to prepare for the Council on the Accreditation of Rehabilitation Facilities (CARF) as mandated by Dr. Kizer.

VISN 1 management staff maintains frequent communication with national and local PVA leadership. Monthly meetings and impromptu encounters at Brockton/West Roxbury with the New England PVA President provide numerous opportunities for communication and discussion of issues related to SCI. The Northeast Paralyzed Veterans of America maintains offices at both the Brockton and West Roxbury Divisions and the President serves on the VISN Management Assistance Council representing the Boston area sub-region Management Assistance Council.

- **Amputee Program** – The thrust of this program is to decrease the need for amputation of lower extremities from preventable diseases. This operates at three levels in VISN 1. Primary care physicians focus on primary prevention, which attempts to identify patients at risk for amputation. Appropriate education, treatment and follow up are employed to help preclude the need for amputation. At the secondary level, formal Preservation Amputation Care and Treatment (PACT) teams, which include Physical Medicine and Rehabilitation, Peripheral Vascular Surgery, Podiatry and the Wound Care Nurse are employed. These multi-disciplinary teams evaluate patients to determine if they are candidates for revascularization and provide them with an appropriate exercise program. Plans of care and follow up appointments are utilized to try to avoid the need for amputation. Finally, for those patients who have already experienced a full or partial amputation of a limb, efficient and effective rehabilitation is provided and appropriate prosthetic devices

provided. Regular surveillance of both the amputation site and the contralateral leg are instituted. The PACT Team and Primary provider work closely together on these high-risk individuals.

The recent changes in eligibility legislation have increased the funds spent on prosthetic devices in general. No veteran in VISN 1 has been denied a prosthetic for which they were eligible based on funding issues and our timeliness in filling orders is excellent. We have decreased the waiting time for specialty appointments and continue to work to improve on all aspects of customer service. Our efforts to improve customer service are evident in that our scores in this area are among the highest of all VISNs.

- Chronic Mental Health – Mental Health Services in VISN 1 encompass a comprehensive program of inpatient and outpatient services for mentally ill veterans. Just like the rest of VA, VISN 1 is transitioning to an emphasis on outpatient care. However, in FY 97, VISN 1 had 555 beds for mental health patients. Among these were 320 beds for acute care (including 49 substance abuse beds) and 235 beds for chronic patients. This is a higher ratio of mental health beds per veteran than the national average. It is likely this number will decrease over time, but VISN 1 programs are designed to make certain that no patient is discharged without an appropriate placement. Overall, eight of the nine VISN 1 facilities provide inpatient mental health services, ensuring availability throughout the network. VISN 1 strives to provide a complete continuum of care for the veteran, from in-patient services to outpatient services and with intermediate programs for rehabilitation and specialized community residential programs. There are an additional 111 beds for residential rehabilitation programs for veterans with chronic mental illness and those with substance abuse problems. This and similar non-inpatient programs are likely to increase over time. To serve the seriously mentally ill (SMI), VISN 1 was a pioneer in developing intensive psychiatric

community care (IPCC) programs, which, by offering extensive support to SMI veterans, allows them to remain in the community. There are now 4 IPCC programs in the VISN and one of them, Brockton/West Roxbury, was ranked highest nationally for FY97 in terms of maintaining individuals in the community.

There are extensive outpatient services in general psychiatry, substance abuse, post traumatic stress disorder, geriatric psychiatry, and for dual diagnosis patients, those with substance abuse in addition to other major diagnoses. There are more than 58 separate outpatient facilities providing extensive geographic coverage throughout the VISN. In FY97 these facilities served approximately 37,000 veterans, who were treated in approximately 739,000 outpatient visits.

In addition, VISN 1 has provided important special programs for the mentally ill. Among our specialized services are two of the nine federally funded programs for the treatment of veterans with co-morbidities of PTSD and substance abuse. There are specialized programs designed to meet the mental health needs of female veterans, including a "women's only" inpatient unit, a rarity in the VA.

VISN 1 also is well equipped to meet the needs of the homeless veterans with the availability of two domiciliary programs, which have both residential and rehabilitative components for their patients, who typically have mental health and/or substance abuse problems. The domiciliary program provides these veterans with skills needed for successful entry into the community as productive citizens. In addition, VISN 1 has developed a specific VISN-wide Homeless Strategic Plan that has been recognized at the national level as a model for strategic planning for the homeless. We have appointed Homeless Coordinators at each facility in VISN 1 and their efforts have resulted in a

15% increase in the number of homeless veterans who have been identified. We have also seen a significant, positive increase in collaboration with community providers that has facilitated the care of homeless veterans through partnerships with community providers.

With respect to monitoring the adequacy of services provided, VISN 1 adheres to the national performance standards established by Dr. Kizer. These include the performance guidelines of having patients seen within 30 days after discharge, administration of the GAF (global assessment of functioning), and the Addiction Severity Index (ASI). Current VISN statistics indicate that 76% of our patients are seen within 30 days of discharge, as compared with a national VA average of 68%. The GAF and ASI are being administered in this fiscal year so as to provide a baseline and an objective index for the effect of our treatment on these measures in the veteran population. In terms of National benchmarking our Mental Health leadership follows closely the statistics on Mental Health performance and "Report Card" furnished by the Northeastern Program Evaluation Center. Overall, for FY97 VISN 1 ranked 7<sup>th</sup> out of the twenty two VISNs (1=best). Our ranking on population coverage and outpatient care was 4<sup>th</sup> nationally. On economic performance we were 7<sup>th</sup> and we were 9<sup>th</sup> on customer satisfaction. All VISN 1 Mental Health Facilities were recently (FY98) fully accredited by the JCAHO, with an average score in the 90's.

VISN 1 is fortunate in having, in the Mental Health Leadership and Clinical Care Line, individuals who have also committed academic and research careers to the service of the mentally ill, and especially the seriously mentally ill. Research and education in these areas is a major effort for our Network. VISN 1 has one of the National Mental Illness Research, Education, and Clinical Centers and two of the three National Schizophrenia Centers for basic and clinical research in Schizophrenia. Expertise in addiction treatment

and research has been rewarded by one of our Medical Center's recent funding for a National Institute on Drug Abuse/VA Medication Development Center and even more recent recognition as a VA Center for Substance Abuse Treatment. Our Network also excels in treatment and research on PTSD, with four of the six Divisions of the National Center for PTSD housed in New England. In addition, the total level of funded research in mental illness in VISN 1, both VA- and NIH-funded, is among the highest in the country.

I am very proud of the efforts of the employees of VISN 1 to continue to improve the excellent services they provide to the veterans of New England. I have the privilege to work with staff who are dedicated to providing the best care possible to all our patients. The close ties we have with many excellent medical schools and universities enhance the care we offer as well as the education and research opportunities available to our staff. This enables VISN 1 to offer many outstanding programs of care along the entire continuum of healthcare programs. These four Special Programs are of prime importance in carrying out our assigned mission. They will continue to receive appropriate attention and support in VISN 1.

Thank you for inviting me to speak before you today. I appreciate your support for our efforts to provide the best possible care to our nation's veterans. I would be pleased to answer any questions you might have.

STATEMENT OF  
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ON MAINTAINING CAPACITY TO PROVIDE FOR THE SPECIALIZED  
TREATMENT AND REHABILITATIVE NEEDS OF DISABLED VETERANS  
BEFORE THE SUBCOMMITTEE ON HEALTH  
COMMITTEE ON VETERANS' AFFAIRS  
U. S. HOUSE OF REPRESENTATIVES  
JULY 23, 1998

Mr. Chairman and members of the Committee, I appear before you today to testify about the implementation and management of specialized treatment and rehabilitative needs for disabled veterans in Veterans Integrated Service Network (VISN) 6.

VISN 6, or the Mid-Atlantic Healthcare Network, is comprised of eight healthcare facilities and other VA medical programs in Virginia, North Carolina and Beckley, WV. We have strong academic affiliations with Duke University; the University of North Carolina; Wake Forest University; the University of Virginia; the Medical College of Virginia, and Eastern Virginia Medical School. We serve a growing veteran patient population that has increased over the past two years and a good percentage of these visits require the support of our specialized programs. A dedicated staff of professionals working in our medical centers, two spinal cord injury units, eight nursing homes and a domiciliary provides this support.

The leadership of VISN 6 recognized early the need to give priority to specialized programs in this era of declining resources. We are now in the second year of refining our structures, processes and outcomes to maintain and even expand the capacity to meet our commitments to disabled veterans. The hallmark of our structural changes is characterized by the formation of multidisciplinary teams that are patient focused and that

place authority, responsibility and accountability at the lowest level where care is provided. This concept is known as Service Line Management.

VISN 6 has established pilot service lines in Spinal Cord Injury (SCI), Mental Health and Primary Care/Preventive Healthcare, with Geriatrics and Extended Care to follow. These service lines encompass the majority of specialized programs and Directors of the service lines report to the VISN Director through the Executive Leadership Council. SCI, Mental Health and Primary Care will have independent budgets in FY99 with oversight by their responsible Service Line Directors. For the first time, these teams will be able to respond to the needs of their patients in a timely manner unencumbered by excessive administrative and bureaucratic red tape. It will also enable them to improve the monitoring of resources, to more accurately measure outcomes, increase access, and positively affect patient satisfaction.

As VISN 6 transitions rapidly from eight autonomous and competing medical centers that focused on providing expensive inpatient services, to an integrated healthcare system that pools its resources, emphasis is being placed on bringing services closer to the veteran, increasing access (capacity), sustaining high quality and ensuring a service that is value added.

Increasing access or capacity for specialized programs in an era of declining resources is our top priority and major challenge. VISN 6 has demonstrated the following accomplishments in specialized programs:

- Blind Rehabilitation – VISN 6 has demonstrated a strong commitment to Blind Rehabilitation initiatives with the continued support of Visual Impairment Service Team Coordinators at each VAMC. In March 1997, a Network Coordinator was appointed to ensure consistency in programs for the visually impaired veteran population. VISN 6 refers patients to West Haven, CT and Augusta, GA for residential rehabilitation. Of the 1,894 identified visually impaired veterans in VISN

6, 103 were referred to VAMC inpatient rehabilitation centers and 120 were referred to state programs. The population of legally blind veterans in VISN 6 is anticipated to increase 122% by the year 2005.

- Prosthetics – VISN 6 redirected a portion of its workforce between FY96 and FY98 to generate a 9% increase in FTE that supports its Prosthetics programs. Regarding financial commitment, expenditures for FY98 are projected to exceed FY96 levels by 24%. Concerning access for veterans, total orders received rose by 19.8% from FY96 to FY97. Delayed orders for VISN 6 were at 1.2% of total orders in FY97 and will continue to be below the 2% threshold for FY98. In providing care for veterans with amputations, Preservation and Amputation Clinic and Treatment Programs (PACT) have been established at each facility. The amputation workload evidences a decrease for FY 1998 in keeping with the National trend.
  
- Mental Health – In March 1998 the Mental Health Service line was established with the outcome of expanding and improving the delivery of services in a cost effective, timely manner. From April 1997 to March 1998, mental health patients treated in outpatient programs increased by 13.4% over the number treated in FY96. For this same period, inpatient episodes of care decreased by 17.4%. A core set of mental health services is provided at each facility within VISN 6, augmented by specialized programs at defined VAMCs.
  - Substance Abuse Treatment is provided primarily through a Substance Abuse Residential Rehabilitation Treatment Planning (SARRTP) model, representing a change from the prior inpatient focused model. Each of the facilities in VISN 6 provides detoxification services and a specialized domiciliary-based program at Hampton operates a Substance Abuse Therapeutic Work Program. From April 1997 to March 1998, 4,345 veterans were treated for substance abuse. Of this number, 3,881 were treated in outpatient programs.

- Seriously Mentally Ill – VISN 6 has maintained capacity within the rates reported for national performance. Major improvements have been made over FY97 although we continue to place emphasis on and monitor outpatient continuity and follow-up care. Plans are underway to expand or increase satellite programs, day programs, Intensive Psychiatric Community Care and transitional housing to serve this population.
  - PTSD services in VISN 6 are delivered in close conjunction with staff from Readjustment Counseling Services to link each veteran's treatment into a continuous model. PTSD programs consist of two specialized inpatient units located at VAMCs Salem, VA and Salisbury, NC and primary care clinical teams (PCTs) at the remaining VAMCs. During FY97, the PCTs treated 583 new PTSD patients.
  - Care for the Homeless – VISN 6 has taken proactive steps to monitor the quality and access of homeless services. One of the initial steps was to monitor outreach activities through the Northeast Program Evaluation Center (NEPEC). Additionally, in November 1996, we established a dedicated Network Coordinator for the Homeless. Each medical center also identified a local coordinator who assesses and tracks each homeless veteran identified in a community setting. Both of these actions will ameliorate problems identified with data systems accounting for the numbers of homeless veterans with full effect anticipated upon availability of FY98 reporting data.
- Spinal Cord Injury – As noted, Spinal Cord Injury and Disease (SCI&D) is one of our pilot service lines. This program provides 164 beds for inpatient acute and long term SCI&D care through the centers located at VAMCs Richmond and Hampton, VA. These centers also support three contiguous VISNs. The remainder of our VAMCs have SCI&D Primary Care Teams that provide ambulatory support services for veterans closer to their homes. From FY96 to FY97, there was a 10% increase in our patient workload. To the best of my knowledge, there are no significant access

problems for SCI&D patients in VISN 6.

- Traumatic Brain Injury – Richmond VAMC has been designated as the lead TBI Center in VISN 6 and a Network Coordinator for the program has been named. Waiting time for inpatient admission in 1997 was 1 day, which is less than the national waiting time of 4 days. Waiting time for an outpatient visit in 1997 was 0, in comparison to the national average of 7 days.

I would like to take this opportunity to thank members of the PVA, DAV, VFW, American Legion, and other Veteran Service Organizations for their input and participation on our Management Assistance Council (MAC) and Planning Boards. Although we may not always agree, their input and assistance has been invaluable in the process of change. I would also like to pay special tribute to PVA members Mr. John Malone, our VISN 6 PVA Liaison, and Mr. John Devine and Randy Pieva from West Virginia for their outstanding support on the MAC. I cite them because their health has not allowed them to continue supporting us in recent months.

Mr. Chairman and members of this Committee, I want to assure you that VISN 6 will continue its efforts to fully comply with the spirit and intent of section 1706 of Title 38 USC. Treating more veterans with specialized needs over the past two years has demonstrated our ability to maintain the scope and availability of these programs while even expanding them.

Thank you for your support. I remain available to answer your questions.

**TESTIMONY OF  
GORDON H. MANSFIELD, EXECUTIVE DIRECTOR  
PARALYZED VETERANS OF AMERICA  
BEFORE THE  
HOUSE VETERANS' AFFAIRS  
SUBCOMMITTEE ON HEALTH  
CONCERNING THE VA MAINTENANCE  
OF SPECIALIZED HEALTH CARE SERVICES**

**JULY 23, 1998**

Mr. Chairman, and members of the Subcommittee. Paralyzed Veterans of America (PVA) appreciates this opportunity to present our views on the VA's ability to maintain its capacity to provide specialized health care services for seriously disabled veterans. I am Gordon Mansfield, PVA's Executive Director. I would like to focus my statement on VA's track record in maintaining the very specialized and unique range of health care

services required by PVA members and all veterans with spinal cord injury or dysfunction.

Because of the medically complex nature of these disabilities, veterans with spinal cord injury or dysfunction require a lifetime of specialized care and on-going rehabilitative services. Following World War II the life expectancy of someone who had sustained a spinal cord injury could be measured in months. At the present time, most notably because of medical interventions and treatment protocols developed by the VA itself, veterans with these same disabilities can live long and productive lives. In doing so, they require life-long access to a wide variety of specialized medical care. Nearly 75 percent of PVA members, a larger percentage than any other veterans service organization, look to the VA for all or most of their health care. They do this because of the expertise VA has developed and the unique services provided through its 22 spinal cord injury centers. This type of comprehensive sustaining care cannot be found in the private sector. For this reason, the preservation of the quality and quantity of specialized care provided through this spinal cord health care network is the first priority of PVA's national office and our chapters throughout the United States.

The VA is undergoing massive change, shrinking budgets, decentralization, downsizing, eligibility changes, cost cutting, and consolidations. We have only begun to see the effects these changes will have on the system as a whole. But these changes are already having a devastating effect on the provision of specialized services in many areas.

Decentralization has left more and more local managers to “call the shots as they see them,” ignoring nationally directed mandates for the provision of specialized care. The truth is, we know what is going on in these programs. It is very clear that VA does not yet have the ability to do the same.

The Congress was correct when it inserted language in P.L. 104-262 mandating VA to maintain its capacity to provide these specialized services. But that instruction is being largely ignored.

Is VA maintaining the capacity of its spinal cord dysfunction programs?

The answer is no.

Does VA even have the capability – and the data systems and staff - to tell what that capacity is?

The answer again is no.

This has to stop. If VA isn't going follow the will of Congress. Then the Congress must step in again to see that it does.

**Definition of “Capacity”**

PVA has been working with VHA on many fronts to see that the integrity of the SCD programs can be insured and that the capacity of those programs protected at the same time. On one of these fronts we have challenged the VA’s definition of capacity. The VA has contended that capacity can be judged ultimately by implementing and assessing outcomes measures judging the effectiveness of the care. Such outcome measures currently do not exist and that the subjective nature of attempting to assess the outcome of SCI treatment when dealing with a long term catastrophic disability makes the development of valid outcome measures problematic at best. We believe it was the Congress’ intent in using the word “capacity,” particularly with reference to SCI medicine, to use beds, FTE and resources as the model to determine if VA is maintaining its unique spinal cord dysfunction programs.

**VA’s “Capacity Report” Report to Congress is Inaccurate and Misleading**

PVA monitors the VA’s SCI Centers on a daily basis through PVA national service officers and chapter volunteers who are physically present each day at every one of the VAMCs with an SCI Center. Senior hospital officials are immediately notified of significant problems with care and deviations from congressional or VA mandates. PVA also sends site visit teams, comprised of management and medical professionals, to each SCI Center at least once each year. Copies of PVA’s Site Visit Reports are

provided to senior VA officials including VA Central Office and Network managers. (FY 1998 Site Visit Schedule: Attachment A)

PVA also surveys every patient after discharge from an SCI Center for patient satisfaction and compiles detailed monthly reports based upon those surveys. Additionally, PVA routinely monitors actual and reported operating beds as well as staffing levels at each SCI Center.

Based upon the monitoring described above, PVA maintains an accurate, up-to-date picture of the VA's SCI system, the results of which are continuously shared with senior VA managers.

The VA, however, does not have an accurate reporting system. These facts are reflected in the two reports VA has submitted to Congress regarding Special Program capacity. The numbers concerning the SCI program are inaccurate and paint a grossly misleading picture. The initial Capacity Report in May of 1997 contained a number of shortcomings in the way capacity of the specialized programs were accounted for. Patients, beds, FTE, and dollars were all undercounted. Since the report was to establish a baseline against which all future measures of capacity would be compared, we consider the report unacceptable. ("VHA Capacity Report" analysis by PVA Health Policy Department Attachment B)

Notwithstanding VA's reports, VA's SCI capacity has been substantially reduced throughout the country over the last two years, contrary to the congressional mandate to maintain it.

### **Bed Reduction**

Over the last two years we have observed the VA close SCI beds because hospital staffing reductions result in inadequate staff to safely maintain mandated levels. They then point to their lowered average daily census as a justification for further reducing SCI staffing and, in turn, beds.

SCI centers compute their census on a seven day/week basis and many patients are discharged over the weekend. These discharges skew the data to give a false low. An example of this is Milwaukee where officials told us they had an average daily census of less than 18 and they were staffing for 18 beds. In fact, the two times this year we conducted site visits at Milwaukee (one was a follow up) they had more than 20 patients. What, in fact, happens is that they have 20+ patients during the weekdays, go down to approximately a dozen on the weekends, and this averages out to less than 18. This means that they are severely understaffed Monday through Friday.

Examples of reduced operating beds are:

- Milwaukee reports 38 operating beds when, in fact they have provided staffing for only 18 beds for over a year.
- Albuquerque reports 30 operating beds when, in fact they have never staffed for more than 20 beds since the SCI Center opened.
- Richmond is reporting 100 operating beds when; in fact they have only 80 available for acute care.
- Augusta reports 60 operating beds when; in fact they are only utilizing 45.

### **Staffing**

We obtain, from the local VAMCs, the number of doctors and nurses working at each of the SCI Centers throughout the year. The actual SCI doctor and nurse staffing is only half of what VA has reported to Congress. We have no idea where the VA comes up with the staffing numbers they provide to Congress. We suspect those numbers include positions which are not filled, staff not actually assigned to SCI, and administrative positions. Even these suppositions, however, do not explain a 100% discrepancy between central office staffing numbers and the staffing numbers provided to us by the individual hospitals. VA Central office reports 2052 staff FTE in SCI Centers, but local officials at those centers advise us that they only have 1065 doctors and nurses. (PVA Veterans Benefits Department Staff and Bed Study: Attachment C)

We use the VA-developed guidelines to determine the adequacy of nurse staffing for SCI Centers. But even if we did not, it is simply indisputable that there is a severe shortage of nurse staffing at VA SCI Centers, by any reasonable standard. Our last four site visits revealed the following:

- Milwaukee (July 8 site visit) – The SCI Unit was 8 nurses short for 26 patients on the day of our visit
- Miami (July 6-8 site visit) – The SCI Unit was 9 nurses short and 2 doctors short for 33 patients on the day of our visit.
- Hampton (June 10-11 site visit) – The SCI Unit was 12 nurses short for 53 patients on the day of our visit.
- Richmond (June 8-9 site visit) – The SCI Unit was 17.5 nurses and 3 doctors short for 80 patients on the day of our visit.

These staffing numbers are typical of what we find at most VA SCI centers during our site visits. We provide our findings, in the form of a site visit report to Central Office and local officials.

### **Leadership**

The quality of SCI care has demonstrably suffered from a lack of leadership in a number of VA SCI Centers.

Examples:

- Long Beach – The position of SCI Chief has been unfilled for more than two years. The outcome of this is the SCI doctors and nurses openly feud with one another and the morale of both has suffered. With no one in charge, doctors and nurses have been unable to agree as to who is responsible for what. For over a year those doctors and nurses have been engaged in an ongoing disagreement as to what the duties of a nurse case manager should be, with the result that the case management program is in total disarray.
- Cleveland – The position of SCI Chief has been unfilled for over a year. During our last site visit in March 1998, we found one doctor trying to care for 37 patients. Hospital leadership is totally oblivious to the obvious unsafe conditions on the wards.
- Milwaukee - The position of SCI Chief has been unfilled for over a year. During our site visit in July 1998, we found one of the two SCI wards had been closed and 21 patients were in rooms which had been designed to hold 18 beds. We also found unsafe equipment being used. There was an absence of necessary equipment because other services at the hospital had, literally, taken equipment off the SCI unit during the dead of night.

- West Roxbury – The SCI Chief resigned because he was not included in the planning at the VISN level for SCI.
- Tampa, Hampton, and Miami are operating with half-time SCI Chiefs. In Tampa, the SCI Chief is also Chief of Rehab Medicine.

### **Long Term Care**

There is a severe shortage of long term care beds for our SCI population. To date there are only three available facilities that offer long term care to SCI patients: Hampton VAMC, Brockton VAMC, and a Residential Care Facility (RCF) at Hines VAMC. All of these facilities are located in the Eastern half of the United States, thereby making woefully inadequate long term bed space for patients from the Western part of the country.

### **Quality of Care**

Unfortunately, the quality of care suffers as a result of the VA's failure to maintain sufficient beds, staff, adequate leadership, and a satisfactory number of long term care beds. The examples that follow are just the tip of the iceberg in quality care issues.

- Milwaukee – At the time of our July 8, 1998 site visit, every SCI doctor reported that they had delayed admissions, cancelled surgeries, and had a backlog of annual evaluations because of lack of available SCI bed space.
- Milwaukee – During our site visits we observed patients not being bathed regularly; remaining in bed until noon; and required to go to bed early because of nursing shortages.
- Milwaukee (July 8 site visit) - Hospital officials admitted to us that they were only providing staffing for 18 operating beds. However, there were 26 patients on the day of our visit, 6 of them on a ward that was monitored by only one nurse, which is not only illegal but unethical.
- Miami – One SCI patient had to be admitted to a medical unit because there were no beds available on the SCI Unit.

#### **VA Decentralization Weakens VA Design/Construction Oversight Process & Standards**

Paralyzed Veterans of America is concerned that VA's facility planning, design, and construction system has become seriously flawed and has lost its ability to ensure the development and maintenance of timely, quality, cost-effective facilities for our nations

veterans. PVA, for many years, has provided the oversight and consultation of our own team of architects to monitor and review VA's compliance with standards for construction of SCI centers and other VA facilities. By the observations of our architects, these deficiencies appear to be due, in part, to the decentralization of Department functions without providing for a mechanism to ensure proper facilities development, compliance with basic minimum standards, and a uniform facilities assessment methodology as a basis for capital improvements. These deficiencies directly undermine VA's ability to maintain its capacity and improve access to specialized services needed by severely disabled veterans. The following examples illustrate not only the seriousness of the problem, but also a growing trend that appears to be emerging within the system:

- ***Established VA and Federal Design Standards are Disregarded***

PVA has followed up on reports from PVA Chapters concerning VA facilities that do not meet Uniform Federal Accessibility Standards and established VA design standards. In response, PVA's National Architecture Program staff obtained design/construction documents for the projects in question, and found serious deficiencies that, in many cases, would preclude a veteran using a wheelchair to gain access to the facility. For example, a recently proposed construction project at the Kansas City VA Medical Center was intended to provide newly renovated facilities for severely disabled veterans, including those with spinal cord injuries. PVA's review of the design drawings revealed that virtually every room failed to meet

Federal Accessibility Standards, and design criteria for spinal cord injury care was totally ignored. VA officials explained that they were either unaware that standards exist, or that the standards are only guidelines, and therefore can be disregarded at the discretion of the medical center. Similar instances have occurred at VA medical centers in Long Beach, San Juan, Sepulveda, Chicago, Milwaukee, and Boston.

- ***Industry Standards for Project Design not Followed***

In the absence of standardized procedures for project development, VA medical centers are developing projects, which appear to be inconsistent with industry norms and statutory accessibility standards. For example, PVA recently visited the Milwaukee VA Medical Center to inquire about proposed plans to relocate a spinal cord injury facility. The medical center staff presented final design drawings, prepared by non-architects, without the benefit of VA SCI Center design criteria, and had just secured the services of a local architect to create construction documents. When PVA architects pointed out that the proposed design violated the 1968 Architectural Barriers Act and did not conform to VA design standards, they cancelled the project.

PVA believes that these examples are indicative of a widespread systemic problem that threatens the viability of the VA System, particularly for veterans with spinal cord dysfunction. These problems will only become more exacerbated with the planned

further reduction of VA Office of Facilities Management personnel who develop and maintain design and construction standards for a national system of 171 medical centers and over 500 satellite clinics. In particular, the decentralization of the VA health care system will only be effective if a meaningful support framework is retained to provide uniform standards for medical care and facility design. Without an appropriate oversight process, providing some form of “checks and balances,” the VA system may soon become 22 separate systems with wide-ranging levels of disparate care, inaccessible facilities, and inadequate quality control.

PVA believes this issue requires urgent consideration at the highest levels of the department and the Congress prior to any further downsizing, or decentralization, of the Office of Facilities Management.

**Construction Priorities:**

A major test of the capacity to provide specialized services such as SCI care is the willingness of the VA to maintain its physical space by constructing and renovating SCI centers. In this area as well the department is falling short.

Tampa Replacement SCI Center: For well over a decade, VA has identified the need to replace the Tampa SCI center. The existing center has one of the highest demands for care in the VA system, and yet it continues to suffer from major space deficiencies and

even life safety violations. The design for the project has already been completed and yet, to date VA has refused to include construction funding in their budget submissions. The House Committee on Veterans' Affairs has authorized the project on two separate occasions. Earlier this year, then Acting Secretary, Herschel Gober assured PVA and House Committee Member, Representative Michael Bilirakis that construction funding (\$20 million) would be included in the FY 2000 budget submission. We hope the Department holds to this promise.

Puerto Rico Replacement SCI Center: The House Appropriations Committee and the full House have approved FY 1999 funding for a major construction project in San Juan, Puerto Rico. Funding for the project (\$50 million) was to have included a 15-bed SCI Center. We understand now, however, that project funding shortfalls are leading project managers to reconsider the elements of the project. Under one scenario, the needed SCI beds would be eliminated. Such a move is intolerable and must be stopped.

**Recommendations:**

**Need for Centralized Management:** Based on VA's track record so far, the best case scenario to protect spinal cord dysfunction centers and programs would be to centralize their management, budget and oversight functions at the National Headquarters Level. These are distinct programs with distinct physical space, identifiable resources and staffing. They serve an identifiable patient population with an identifiable curriculum of

services: The SCI centers, in particular, at the present time have been left to flounder, subject to the disinterest of National Headquarters leadership and the cost-cutting whims of VISN and hospital directors trying to reshape their functions into experimental management schemes.

Long-standing VA treatment guidelines for SCI care, such as VA Manual M-II, Part 24, are being largely ignored. Local managers are inventing their own pathways to care. Instead of one national system for SCI care, the VA has a growing pattern of 22 different SCI systems. What follows are wild variations in care from one hospital to the next and one VISN to the next. What has been a carefully sculpted nationwide program, providing pre-eminent leadership in the field of SCI medicine, is definitely at risk. The Congress needs to bring the reins back in. These programs need leadership not avoidance.

**Need for Improved Management Information Systems:** First and foremost, VA needs the information and data systems to be able to accurately define its capacity for care. As clearly seen in the recent reports to Congress, VA measurement systems are grossly inaccurate and wholly inconsistent from one VISN to the next. An adequate data collection system also requires trained personnel to collect and analyze that data.

**Need for Improved Staffing for SCI Chief Consultant:** The SCD system has an office of the Chief Consultant for the Spinal Cord Injury and Disorders Strategic Healthcare Group which could serve as proper data collection center. However, that office is

certainly not staffed to accept this needed role. The Congress should require the VA to provide additional FTE for this office to provide meaningful data collection and analysis functions. To further support this activity, each VISN should appoint staff charged with assisting the Chief Consultant in the role of oversight and data collection by monitoring the provision of SCD care in their area of jurisdiction.

**Maintenance of Specialized Services Should Be Included in VISN Management**

**Performance Measures:** The maintenance of capacity for all specialized services, including SCD care, should be made part of the performance measures for management personnel from the level of the VISN director on down.

**VA Should Fill Vacant Positions in SCI Centers:** As stated previously, PVA is also concerned about the length of time being taken to fill critical staff vacancies in its SCI Centers. Most notably are the vacancies in VA SCI Chiefs. These vacancies have a direct effect on morale of staff and the quality of care. While some difficulty in recruiting qualified individuals to accept employment with VA may be understandable, VA is still not using the broad authority that is available to obtain these needed personnel on a contractual basis while permanent employment recruit continues. These authorities are used routinely by the VA to obtain other scarce medical specialties such as radiologists and anesthesiologists. SCI Center Chiefs are no less important. Rather than leaving these crucial positions vacant for extended periods, VA should use its expanded

sharing (38 USC 8153), or scarce medical specialists (38 USC 7409) authority to fill these positions on a contractual basis while employment recruitment continues.

Mr. Chairman, maintaining VA specialized programs and services is PVA's highest priority. Our entire national staff, our extensive network of service officers around the country, and our chapters are committed to this goal. We are determined to see that VA reorganization, cost-cutting, and seeming insensitivity do not undermine the quality and quantity of the care our members have earned and deserved. With your continued help, we will insure that VA's spinal cord dysfunction programs remain strong as one of the recognized core specialized services of the VA health care system.

This concludes my testimony, I will be happy to answer any questions you may have.

**Site Visit Dates**  
**Fiscal Year October 1997 – October 1998**

**October 7 - December 1997**

October 7-9, 1997	Oklahoma City, OK
October 15-17, 1997	Brockton/West Roxbury
October 15-17, 1997	St. Louis, MO
November 4-6, 1997	San Antonio, TX
November 4-6, 1997	Tampa, FL
December 2-4, 1997	Memphis, TN
December 9-13, 1997	Long Beach/Sepulveda

**January 1 – July 8, 1998**

January 6-9, 1998	Houston, TX
January 13-15, 1998	Albuquerque, NM
February 10-12, 1998	Hines, IL
February 17-20, 1998	San Juan, PR
March 3-6, 1998	Cleveland, OH
March 9-11, 1998	Milwaukee, WI
March 31-April 2, 1998	Augusta, GA
April 21-24, 1998	Bronx, NY
May 19-21, 1998	Dallas, TX
June 7-9, 1998	Richmond, VA
June 10-11, 1998	Hampton, VA
June 14-16, 1998	Tampa, FL
July 6-8, 1998	Miami, FL
July 8, 1998	Milwaukee, WI

**August 11 – October 1998**

**Visits to be conducted**

August 11, 1998	Cleveland, OH
September 21-23, 1998	Palo Alto, CA
Sept. 29-Oct. 2, 1998	San Diego, CA
October 6-7, 1998	Oklahoma City, Ok
October 13-14, 1998	St. Louis
October 20-22, 1998	Boston

**Attachment B****VHA Capacity Report Presented to  
the House and Senate Committees on Veterans' Affairs****Paralyzed Veterans of America  
Health Policy Department Analysis****July 15, 1998**

The initial Capacity Report in May of 1997 contained a number of shortcomings in the way capacity of the specialized programs for veterans with spinal cord dysfunction were accounted for. Patients, beds, FTE, and dollars were all undercounted. Since the report was to establish a baseline against which all future Report Presented to the Committees on Veterans measures of capacity would be compared, we consider the report unacceptable. Our concern that future reports could be misleading by introducing workload measures at facilities previously unaccounted for without adjusting the 1996 count appears to be valid in view of the 1998 report. For example, patient counts at SCI clinics operating at Iowa City (35 patients), Fayetteville (30 patients), and Asheville (12 patients), were included in 1997 without identifying how many patients were treated in 1996. Others, which should not have been counted, such as Montrose (34 patients), were included. Review of the report also indicates that patients treated at a number of SCI

clinics known to be operating continue to be absent from the report. The following is a list of these facilities:

Portland  
Oklahoma City  
Wilmington  
Northport  
Lebanon  
West Palm Beach  
Cincinnati  
Grand Island  
Biloxi

In short the method of relying solely on the Patient Treatment File (PTF) to count patients receiving care through the SCI service is inadequate. There appears to be a lack of uniformity in the way facilities code SCI clinic stops. Therefore patient counts and dollars portrayed in the report are not reliable.

#### **SCI BEDS**

The report does show a decline in the number of SCI beds that were staffed for operation from 1996 to 1997. The apparent modest five percent reduction from 1,189 beds in 1996 was actually 13% when PVA field service officers counted beds. This discrepancy is more dramatic when bed days of care that were delivered to SCD patients in bed sections

other than SCI were considered. By adding those bed days of care that could be more appropriately delivered through the SCI program at each of the reported facilities, the total number of SCI beds needed system-wide is 1,282. The attached table provides a comparison between beds in the Capacity Report to Congress, those reported in PVA's field survey, and those suggested in PVA's planning recommendations. Potential referrals from facilities with SCI clinics are also indicated. These are beds that are occupied on a daily basis by patients with SCI at facilities that operate an SCI clinic.

### **Nursing Home Beds**

Nursing home patients are not included in the capacity report, however M2 Part XXIV 2.08 clearly indicates that SCI patients requiring nursing home level care be cared for in a VA facility. PVA's studies of nursing home patients with SCI indicate that development of secondary conditions such as pressure sores is more prevalent in facilities that do not have staff with SCI training. Yet VA continues to place these patients in contract nursing homes.

Discharges from VA medical centers to nursing homes were examined to quantify the use of contract nursing homes to care for veterans with SCI. There was a five percent increase in VA's use of contract nursing homes to care for SCI patients in 1996. Forty more veterans with SCI were discharged to community nursing homes in 1996 than in 1995. The total of 253 veterans represents 43% of the total veterans with SCI discharged to nursing homes.

**Comparison of VA Capacity Report  
with PVA Site Visit Reports and Planning Recommendations**

Numbers Represent Beds		VA Capacity Report		Staffed Beds (VBO)	Planning Recommendation FY1999 SCI Beds			Potential Referrals from Facilities with SCI Clinics	Business Plan Recommended before VBO Report
		FY 1998	FY 1997	April '98	Acute	Long Term	Total	ADC FY1998	
1	Brockton/W. Roxbury *	95	58	55	39	40	79		77
1	Togus							1	
1	Boston							4	
3	Bronx	75	62	60	52	10	62		60
3	Castle Point	41	20	38	0	30	30		25
3	East Orange	25	25	25	25	5	30		34
3	Northport							5	
4	Lafayette							3	
6	Hampton	64	64	64	0	78	78		70
6	Richmond	119	100	80	96	10	106		95
4	Wilmington							3	
5	Baltimore							20	
6	Salem							3	
6	Salisbury							9	
6	Durham							3	
7	Augusta *	60	60	45	50	10	60		56
7	Birmingham							3	
7	Tuscaloosa							4	
8	Miami	36	36	36	25	27	52		33
8	West Palm Beach							2	
8	San Juan	20	20	20	18	6	24		18
8	Tampa	60	60	56	60	34	94		84
8	Orlando (SOC)							0	
8	Bay Pines/Fl. Myers *							7	
9	Memphis	90	90	90	80	10	90		92
9	Huntington							3	
10	Cleveland	38	38	38	30	23	53		46
4	Pittsburgh UD							13	
16	Dulles/Hill							3	
11	Ann Arbor							4	
11	Indianapolis							3	
12	Hines	68	68	68	56	15	71		64
12	Illwaukee	38	38	21	30	8	38		33
13	Minneapolis							4	
15	St. Louis/Jeff. Barracks *	30	30	30	30	10	40		32
14	Des Moines							2	
14	Grand Island							1	
14	Iowa City							3	
15	Wichita							2	
15	Kansas City							3	
16	Houston	40	40	40	38	10	48		42
16	Wiley							6	
16	Jackson							6	
16	Little Rock *							6	
16	Chillicothe City							3	
16	Stevensport							3	
17	Dallas	13	30	30	30	5	35		16
17	San Antonio	30	30	30	20	5	25		22
18	Albuquerque	30	30	20	18	5	23		21
18	Phoenix							4	
18	Tucson							2	
20	Seattle	38	38	32	30	10	40		32
19	Portland							3	
21	Palo Alto	48	48	48	54	14	68		64
22	Long Beach	120	120	90	81	31	112		98
22	San Diego	20	20	20	21	3	24		21
22	Sanjuegos							0	
<b>ALL SCI Program Facilities</b>		<b>1,189</b>	<b>1,125</b>	<b>1,039</b>			<b>1,282</b>		<b>1,116</b>

\*Outpatient Workload reported in parent facility workload.

Note: Shaded lines indicate facilities that operated an SCI clinic but were excluded from the capacity report.

Attachment C

## VA Spinal Cord Injury Center Capacity Shortfalls

## Reported vs. Actual

	Inpatient Beds				Staff Positions			
	SCI Inpatient Beds Reported to Congress May, 1997 <sup>1</sup>	Actual SCI Inpatient Beds April, 1998 <sup>2</sup>	Variance Between Reported & Actual	Percent Variance Reported v. Actual	SCI Staff Positions Reported to Congress May, 1997 <sup>1</sup>	Actual MD/Nurses Staff April, 1998 <sup>2</sup>	Variance Between Reported Staff <sup>3</sup> & Actual MD/Nurses Staff	Percent Variance Reported v. Actual
VAMC SCI Center Albuquerque, NM	30	20	-10	-33%	95	25.3	-69.7	-74%
Augusta, GA	60	45	-15	-25%	120	62.0	-58.0	-48%
Brookton/W. Rox, MA	95	55	-40	-42%	189	63.0	-126.0	-67%
Bronx, NY	75	60	-15	-20%	106	37.0	-69.0	-65%
Castlepoint, NY	41	36	-5	-12%	42	26.8	-15.2	-36%
Cleveland, OH	38	38	0	0%	83	82.0	-1.0	-1%
Dallas, TX <sup>4</sup>	13	30	17	131%	45	42.0	-3.0	-7%
East Orange, NJ	25	25	0	0%	53	26.0	-27.0	-51%
Hampton, VA	64	64	0	0%	84	49.4	-34.6	-41%
Hines, IL	68	68	0	0%	183	44.0	-139.0	-76%
Houston, TX	40	40	0	0%	72	52.5	-19.5	-27%
Long Beach, CA	120	90	-30	-25%	208	96.9	-111.1	-53%
Memphis, TN <sup>5</sup>	90	90	0	0%	183	63.0	-120.0	-66%
Miami, FL	36	36	0	0%	26	31.1	5.1	20%
Madison, WI	38	21	-17	-45%	66	35.7	-30.3	-46%
Palo Alto, CA	48	48	0	0%	131	50.1	-80.9	-62%
Richmond, VA	110	80	-30	-27%	169	87.0	-82.0	-49%
San Juan, PR	20	20	0	0%	28	17.0	-11.0	-39%
San Antonio, TX	30	30	0	0%	46	36.3	-9.7	-21%
San Diego, CA	20	20	0	0%	48	28.3	-19.7	-41%
Seattle, WA	38	32	-6	-16%	42	45.4	3.4	8%
St. Louis, MO	30	30	0	0%	51	24.2	-26.8	-53%
Tampa, FL	60	56	-4	-7%	138	81.1	-56.9	-41%
<b>Total</b>	<b>1,188</b>	<b>1,038</b>	<b>-150</b>	<b>-13%</b>	<b>2,107</b>	<b>1,095</b>	<b>-1,012</b>	<b>-48%</b>

<sup>1</sup> Taken directly from VA's May, 1997 Report to the Committees on Veterans Affairs of the Senate and House of Representatives.<sup>2</sup> On April 2, 1998, PVA staff physically counted operating beds at each VA SCI Center.<sup>3</sup> Taken directly from VA's May, 1997 Report to the Committees on Veterans Affairs of the Senate and House of Representatives.<sup>4</sup> On April 2, 1998, PVA staff obtained the number of MD and Nurse FTEE from VA supervisory staff at each of the VA SCI Centers.<sup>5</sup> When VA reported to Congress, the Dallas SCI Center had just opened and was not up to authorized capacity.<sup>6</sup> The Hospital Director has announced his intention to close 18 SCI beds by October 1, 1998.<sup>7</sup> Staff positions measured in Full Time Employee Equivalents (FTEE)Paralyzed Veterans Of America  
9/26/98 4:48 PM SCICapacityR23.xls

**GORDON H. MANSFIELD  
EXECUTIVE DIRECTOR**

Gordon H. Mansfield was appointed executive director of the Paralyzed Veterans of America (PVA) in April 1993. In this position, he oversees and directs the daily operations of PVA's national office.

From 1989 to 1993, Mr. Mansfield served as assistant secretary for Fair Housing and Equal Opportunity at the Department of Housing and Urban Development (HUD), where his responsibilities included enforcement of the Fair Housing Law.

From 1981 to 1989, Mr. Mansfield held a number of positions at PVA, including serving as the organization's first associate executive director of Government Relations.

Prior to joining PVA, he practiced law in Ocala, Florida, specializing in poverty-related litigation.

Born September 15, 1941, in Pittfield, Massachusetts, he earned a B.A. in 1964 from Villanova University and a law degree from the University of Miami.

Following his graduation from Villanova, Mansfield enlisted in the Army. In 1968, during his second tour of duty in Vietnam, while serving as company commander with the 101st Airborne Division, Mansfield sustained a spinal cord injury. His combat decorations include the Distinguished Service Cross, the Bronze Star, two Purple Hearts, the Combat Infantryman's Badge, and the Presidential Unit Citation.

Mr. Mansfield is a recipient of the Presidential Distinguished Service Award; the Villanova University Alumni Human Relations Medal; and, was inducted into the U.S. Army Officer Candidate School Hall of Fame in 1997.

Mansfield resides with his wife Linda in Alexandria, Virginia.

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Information Required by Rule XI 2(g)(4) of the House of Representatives

Pursuant to Rule XI 2(g)(4) of the House of Representatives, the following information is provided regarding federal grants and contracts.

**Fiscal Year 1998**

General Services Administration—Preparation and presentation of seminars regarding implementation of the Americans With Disabilities Act , 42 U.S.C. §12101, and requirements of the Uniform Federal Accessibility Standards — \$15,000.

Department of Veterans Affairs— Donated space for veterans' representation, authorized by 38 U.S.C. §5902, — \$243,912\* (as of December 31, 1997).

Court of Veterans Appeals, administered by the Legal Services Corporation — National Veterans Legal Services Program— \$63,656 (as of December 31, 1997).

**Fiscal Year 1997**

Architectural and Transportation Barriers Compliance Board— Develop illustrations for an Americans With Disabilities Act, 42 U.S.C. 12101, technical compliance manual— \$10,000.

Department of Veterans Affairs—Donated space for veterans' representation, authorized by 38 U.S.C. §5902, — \$975,651.\*

Court of Veterans Appeals, administered by the Legal Services Corporation — National Veterans Legal Services Program— \$238,307.

**Fiscal Year 1996**

General Services Administration— Preparation and presentation of seminars regarding implementation and the Americans With Disabilities Act , 42 U.S.C. §12101,— \$25,000.

Federal Elections Commission— Survey accessible polling sites resulting from the enactment of the Voting Access for the Elderly and Handicapped Act of 1984, P.L. 98-435, — \$10,000.

Department of Veterans Affairs— Donated space for veterans' representation, authorized by 38 U.S.C. §5902, — \$897,522.\*

Court of Veterans Appeals, administered by the Legal Services Corporation — National Veterans Legal Services Program — \$200,965.

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\* This space is authorized by 38 U.S.C. § 5902. These figures are estimates derived by calculating square footage and associated utilities costs. It is our belief that this space does not constitute a federal grant or contract, but is included only for the convenience of the Committee.

STATEMENT OF  
JACQUELINE GARRICK, ACSW,  
DEPUTY DIRECTOR, HEALTH CARE  
NATIONAL VETERANS AFFAIRS AND REHABILITATION COMMISSION  
THE AMERICAN LEGION  
BEFORE THE  
SUBCOMMITTEE ON HEALTH  
COMMITTEE ON VETERANS' AFFAIRS  
UNITED STATES HOUSE OF REPRESENTATIVES  
ON  
VA SPECIALIZED AND REHABILITATION TREATMENT OF  
DISABLED VETERANS

JULY 23, 1998

Mr. Chairman and Members of the Subcommittee:

The American Legion is grateful for the opportunity to comment on the Department of Veterans Affairs (VA) implementation of section 1706 of title 38, USC, and its management of these special programs. After reviewing VA's report to the Committees on Veterans' Affairs of The Senate and House of Representatives on "Maintaining Capacity to Provide for the Specialized Treatment and Rehabilitative Needs of Disabled Veterans," The American Legion has several concerns.

Public Law 104-262 Section 104 mandates VA to protect its capacity to meet the specialized treatment and rehabilitation needs of disabled veterans within existing appropriations. The law is aimed at maintaining capacity in a manner that provides reasonable access to care for Spinal Cord Dysfunction, Blindness, Traumatic Brain Injury, Amputations, and Seriously Mentally Ill including Substance Abuse, Homelessness, and Post Traumatic Stress Disorder. The Balanced Budget Agreement requires VA to meet this challenge with no significant increase to its buying power. The American Legion questions VA's ability to "do more with less" in these highly technical and complicated treatment arenas.

The American Legion commends Congress for its foresight to ensure the scope and quality of these specialized programs are maintained. VA is often the only local provider, and is the unparalleled national leader in providing these services. Monitoring these programs is particularly important in light of VA's challenge to maintain capacity with a budget that will not keep up with inflation. There is evidence that suggests these programs warrant continued monitoring so that there is no diminution of special services. For example, since the enactment of P.L. 104-262, there has been a significant increase in the demand for prosthetic devices. The FY 98 second quarter report of Delayed Prosthetic Orders shows a 125 percent increase in delayed orders with eighty percent attributed to an increased workload with insufficient staff. The monitoring of capacity contributes to the ongoing observations and evaluations of such issues. Ongoing evaluation and research is necessary to maintain program integrity and viability. Ultimately, it is hoped that when such circumstances are identified, corrective actions will be taken by VA.

The effort to maintain capacity has involved challenges in terms of defining capacity and how to effectively measure it. Preliminary monitors have included the number of unique individuals treated and dollars expended with some consideration to bed levels and Full Time Employee Equivalent (FTEE). There appears to be consensus that outcomes should be used in determining capacity. However, this will be in the future as it will take time to develop measures and collect meaningful data. While The American Legion concurs with the importance of outcome measures in assessing capacity, it also believes there is merit in

monitoring the current parameters, in particular, dollars expended. The VA's Committee on Care of Severely Chronically Mentally Ill Veterans (CCSMI) observed that a decrement in continuity for substance abuse treatment, and the drop in numbers of veterans treated was accompanied by fewer resources invested in the two VISNs with the most significant drop in performance. The American Legion recommends measuring capacity by evaluating resources expended with patients treated, and then documenting outcome.

According to VA's second report on maintaining capacity (May 1998), capacity, as measured by the number of unique individuals served nationally in the programs, has been maintained. Capacity, as measured by resources expended, has dropped in some cases, often reflecting a shift to outpatient care modalities. While The American Legion recognizes VA's ongoing commitment to these programs, there have been challenges in meeting the mandate to maintain capacity at the level commensurate to the time of the [promulgating] legislation (October 1996). In two networks, 8, headquartered in Bay Pines, and 18, headquartered in Phoenix, there are no long term mental health services available. The American Legion views this as an inequitable distribution of capacity, in spite of the overall national average being maintained. This does not seem to be a logical conclusion, nor does it seem to be in keeping with the spirit of the law.

The American Legion is also concerned with the definition of access used by VA as being limited to timeliness. The American Legion VA Locale User Evaluation (VALUE) Workbook defines access "by the key characteristics of market penetration broken down into both medical groups under VERA, as well as, by the seven priority groups and the quantifiable measures aimed at providing the most accurate picture of the availability of health care services such as timeliness of appointments and availability of diagnostic services." ( See Attachment A.) If VA only measures timeliness, it does not get a full perspective of veterans' access to VA specialized programs.

The main criticism of this year's Capacity report to Congress has been the unreliability of the data. Both advisory committees noted serious shortcomings with the data collection. The Advisory Committee on Prosthetics and Special Disabilities Programs (ACPSPD) went so far as not to endorse the draft report because of the flawed data. VA has acknowledged the necessity for more timely reliable information so that Network Directors can respond to program changes and correct problematic areas. Obviously, VA's efforts to monitor these specialized services are contingent upon its ability to garner accurate data.

The inaccuracy in the VA data on Spinal Cord Dysfunction has been well documented by the Paralyzed Veterans of America (PVA). Capacity has been grossly under-reported by VA. In addition, there is no consistency in the workload data for FY 96 and FY 97. Therefore, it is not a reliable measure for capacity.

In addition, VA reports that both dollars expended and patients treated increased from FY 96 to FY 97 by three percent and four percent, respectively. However, FTEE and operating beds decreased by six percent and five percent, respectively. This seems inconsistent since FTEE and operating beds would be the primary source of expenditures. If these are down, then where else are the costs? How are these unknown costs being documented and monitored?

The American Legion sits on the VA's Consumer Counsel for the Committee on Care of Severely Chronically Mentally Ill Veterans (CCSMI), and was involved in the development of its Second Annual Report to the Under Secretary for Health, February 12, 1998. The American Legion praises the SMI Committee for all its work on behalf of veterans with disabling psychiatric disorders, and refers Congress to its comments on capacity in section II, "Treatment Delivery to Seriously Mentally Ill Veterans," of this report. In addition, the SMI Committee report also includes the FY 97 report from Dr. Robert Rosenheck on the Mental

Health Performance Monitoring System. The American Legion finds this to be a significant reporting mechanism, and has referred to it several times when conducting its own site visits. The mental health report card is a valuable tool in assessing quality of care, which is a crucial element in accessing capacity. Capacity becomes meaningless without incorporating quality and patient satisfaction.

The American Legion would like to take this opportunity to share previous experience with trying to analyze the data VA currently has submitted to Congress. The American Legion Field Service visited the Cleveland VAMC Center of Excellence for Homeless Veterans during February 18-20, 1998. At that time, Field Service Representatives identified concerns with VA data on homeless veterans treated, and the dollars spent on these services. The American Legion noted the Northeast Program Evaluation Center Reports for FY 96 and 97 indicated a drop in veterans treated by 238 (going from 433 in FY 96 to 297 in FY 97) while at the same time the Cleveland Center was declared a Site of Excellence. In a June 2, 1998, follow up letter to The American Legion from Laura Miller, Network Director, VISN #10, she stated, "This report (first draft of FY 98 report on Capacity for Congress) contained a major error in calculating the number of veterans receiving specialized homeless services and the dollars spent on such services." She goes on to explain how the problem arose, and provides a new FY 97 figure of 432 veterans served. However, according to the report released to Congress Appendix A, Table 1A-5b, the FY 97 figure for veterans seen in Cleveland is 498. According to Ms. Miller, VISN #10's cumulative numbers for veterans treated was 848 in FY 97 which is below the FY 96 figure of 953. However, again, the report to Congress shows a different figure of an increase to 1,056. (There are similar discrepancies in the dollars expended.) This is inconsistent data, and, although an isolated example, The American Legion cannot help but question the validity of the numbers reported.

In sum, The American Legion finds the VA report on maintaining capacity to be flawed in a myriad of its methodologies and conclusions. It is incomplete since it is yet unable to report on outcomes. Capacity cannot be defined without an understanding of quality. The American Legion urges VA to utilize the expertise it has within its own resources, like the National Center for PTSD, and develop appropriate outcome measures. These measures should be instituted in conjunction with existing input measures, and not replace them. Yet, the overarching concern for capacity begins with the Balanced Budget Agreement, and VA's ability to continue to provide specialized care to all veterans who will need it in the twenty-first century.

Mr. Chairman, that concludes this statement.

REFERENCES

"Maintaining Capacity to Provide for the Specialized Treatment and Rehabilitative Needs of Disabled Veterans." Report to the Committees on Veterans' Affairs of Senate and House of Representatives (Public Law 104-262, Section 104). Office of Policy and Planning, Veterans Health Administration, Department of Veterans Affairs. May 1998.

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"VA Locale User Evaluation Workbook." The American Legion. 1998.

"VHA Capacity Report Presented to the Committees on Veterans Affairs of the Senate and House of Representatives" Paralyzed Veterans of America, Health Policy Department Analysis. July 15, 1998.

**STATEMENT OF**  
**RICHARD A. WANNEMACHER, JR.**  
**ASSOCIATE NATIONAL LEGISLATIVE DIRECTOR**  
**OF THE**  
**DISABLED AMERICAN VETERANS**  
**BEFORE THE**  
**COMMITTEE ON VETERANS' AFFAIRS**  
**SUBCOMMITTEE ON HEALTH**  
**UNITED STATES HOUSE OF REPRESENTATIVES**  
**JULY 23, 1998**

MR. CHAIRMAN AND MEMBERS OF THE SUBCOMMITTEE:

I am pleased to appear before you to present the views of the more than one million members of the Disabled American Veterans (DAV) and its Women's Auxiliary on the Department of Veterans Affairs' (VA's) mission of providing for the specialized treatment and rehabilitative needs of disabled veterans.

The DAV, AMVETS, Paralyzed Veterans of America (PVA), and Veterans of Foreign Wars of the United States (VFW) join together each year to assess the state of veterans' programs and its funding resource needs. We present our collective views on policy questions, programmatic issues, and resource requirements.

Since we are not motivated or constrained by the politics of the Federal budget process, our analyses are more objective and can be more candid than the assessments presented by VA officials. Because our goals are purely related to what is best for veterans and thus what is best for their programs, and because we are not concerned with the political exigencies of the moment, we focus on long-term efficiency and effectiveness rather than short-term, budget-driven goals inherent in the Administration's approach. We therefore believe our recommendations more accurately reflect the resources necessary to enable VA to provide an acceptable level of benefits and services for our Nation's more than 25 million veterans, their dependents and survivors.

This year, as we have done for the past 12 years, we have prepared our analysis and recommendations in addressing VA's program-specific strategies and goals in the major sections of the *Veterans Independent Budget and Policy--Fiscal Year 1999 (IB)*.

Within the medical programs section, the *IB* addresses the specialized services mission of the VA. Some programs are "special" because of the population they serve, while others are "special" by statute (section 1706 of title 38, United States Code).

The specialized services section of the FY 1999 *IB* discusses community-based outpatient clinics, services for blind veterans, spinal cord injuries, services for homeless veterans, services for women veterans, prosthetics and sensory aids, and services for veterans with serious mental illness.

Because the four organizations work closely throughout the year, we have agreed to limit our testimony today to the specific areas with which we are most familiar in addressing the capacity of specialized services. The DAV has been honored with the opportunity to serve on both the Advisory Committees on Prosthetics and Special Disabilities and on the Consumer Advisory Council to the Committee on Care of Severely Chronically Mentally Ill Veterans.

#### **PROSTHETICS AND SENSORY AIDS**

In the past, prosthetics funding had been centrally based to ensure that services for prosthetics and sensory aids were provided when medically needed. We have been advised that with the shift of funding to the local level, shortages and delays have occurred causing veterans to forego necessary services until funding is made available.

We understand that funding for prosthetics and sensory aids, rather than being centrally controlled to allow for monitoring and reserved for later use will be based on Veterans Equitable

Resource Allocation (VERA). We are concerned that with the flat-lined appropriation, staffing shortages within prosthetics and sensory aids service will force continued delays in orders and will not allow for local site visitation, staff training and the monitoring of services delivered.

Internal pressures are being placed on clinicians and managers in providing prosthetics and sensory aids. The National Delayed Prosthetic Order Report for the second quarter of fiscal year 1998 indicates that 8,300 (1.6%) of the current orders (529,826) are delayed. The report also indicates that the predominant reason for the delays was excessive workload in 3,611 cases, followed by staff shortages in 3,073 cases.

Mr. Chairman, this dilemma cannot be allowed to continue. Veterans whose orders are delayed and cannot timely obtain artificial limbs, supplies and devices, wheelchairs, eyeglasses, and hearing aids are being further delayed in their rehabilitation and return to gainful and competitive employment.

In an attempt to fill vacant prosthetic services personnel positions, local VA Medical facilities are transferring other personnel within the facilities who are untrained and unable to fulfill the VA's commitment to these men and women who rely on VA health care for improving their functional abilities.

We recommend the following:

- Veterans Health Administration (VHA) must centrally retain sufficient prosthetics and sensory aids funds and allocate those funds—or excess funds from other VISNs—to VISNs with shortfalls.
- VHA must add at least three full-time employee equivalents to the Strategic Healthcare Group for Prosthetics and Sensory Aids at VA Headquarters.
- VHA clinicians must be allowed to prescribe prosthetic devices and sensory aids based on medical need, not cost.
- VISN directors must ensure that prosthetics and sensory aid departments are fully staffed by appropriately trained teams and directors.

Mr. Chairman, it makes sense to get these veterans rehabilitated and returned to gainful employment as soon as feasibly possible.

#### **SERIOUSLY MENTALLY ILL**

We estimate that as many as 80% of VA users access special programs at some point in their life, and that 20% of the current VA health care population utilizes mental health services.

I would like to publicly express our appreciation to the co-chairs of the Committee on the Care of Severely Chronically Mentally Ill Veterans, Dr. Robert Fowler from VA Medical Center (VAMC) Dallas, Texas, Mr. Stephen Berman from VAMC West Los Angeles, California, and the entire committee for allowing consumer involvement in developing the two reports to Congress, dated February 14, 1997, and February 12, 1998, as well as their openness in providing quality mental health services to this Nation's sick and disabled veterans.

The Consumer Advisory Committee of the Committee on Severely Chronically Mentally Ill Veterans was established in 1996 and now meets with the full committee. Membership on the committee includes representatives of DAV, Vietnam Veterans of America, National Alliance for the Mentally Ill, the American Legion, National Mental Health Association, Substance Abuse & Mental Health Service Administration and PVA.

Since our advisory committee's inception, the committee has developed a stable membership and is now assisted by a part-time coordinator employed by VHA. The advisory committee has attended four meetings with the full committee and is fully incorporated into the committee's operations, including membership on various subcommittees or task forces. The

advisory committee also has a monthly telephone conference call and a monthly newsletter prepared by the coordinator, Mrs. Lucia Freedman.

In the full committee's first report on September 14, 1997, it made 17 recommendations that addressed a variety of issues pertaining to the care of seriously mentally ill (SMI). For the purpose of this most timely hearing, I will only mention a few of the recommendations which we feel bear repeating here today:

- Review proposed bed/program closures and policy proposals in reinvesting cost savings in providing a continuum of care for the seriously mentally ill.
- Simplify data from Northeast Program Evaluation Center (NEPEC) on VA programs that affect mental health programs.
- Publicize successful consumer programs, both VA and non VA.
- Promote anti-stigma training related to mental illness for the VAMCs, which includes personnel from areas other than mental health programs.
- Review policies such as pharmacy protocols and confidentiality guidelines that affect persons with mental illness.
- Have input into development of measures of customer satisfaction.
- Have mental health measures in the VISN director's performance measures.
- Have a veteran mental health consumer on the Consumer Advisory Committee.
- Help develop a national network of VISN and local facility mental health consumer councils.

Additionally, I believe it should be noted that with the decline of inpatient health care delivery, veterans receiving outpatient mental health services increased 5.3% while the non-mental health outpatient services rose 9.7%.

The committee's second report on February 12, 1998 included the following recommendations that have not been addressed, and thus warrant repeating:

- 1) Community Based Outpatient Clinics (CBOCs): "that each Network review the services provided by existing CBOCs and evaluate whether the addition of basic primary mental health services to the seriously mentally ill to those CBOCs currently without such services is warranted." The committee stated that "VHA Directive 97-036 (change 1), requires that all proposals for CBOCs contain an assessment of the need for providing basic primary care mental health services with mental health patients comprising 20% of all VA patients."
- 2) Intensive community case management programs and community residential care programs, adequately sized to the population of SMI veterans in the area, should be established by all appropriate VHA facilities, such as:
  - **Intensive Psychiatric Community Care (IPCC)**, a program that optimizes the health status, quality of life and community functioning of veterans with serious mental illness who are high users of VA mental health inpatient services. This is accomplished by providing individualized, community-based services characterized by capacity for intensive intervention, a practical problem-solving approach, and continuity of care.
  - **Adult Day Care**: Providing health maintenance and rehabilitative service to veterans in group settings during daytime hours. These outpatient programs serve vulnerable populations, such as frail elderly, those with functional or cognitive

impairments such as Alzheimer's disease, and veterans with multiple interactive medical problems, significant social issues and psychological needs.

- **Assisted Living and Transitional Housing:** Funded by enhanced use lease programs, this helps VA bridge the gap between independent living and nursing home care.
  - **Home Based Health Care:** Providing health professionals the ability to monitor and care for severely medically compromised veterans within their homes.
- 3) **Medication Formulary:** Use of new antipsychotic medication, "Clozapine usage has been reviewed at all VA facilities and those with low usage were requested to determine barriers to prescribing Clozapine." The committee conducted a national survey of the use of the new antipsychotic agents throughout VHA. Reports indicated that barriers existed for better education of providers in their use, lack of programmatic structure to support the additional monitoring required by Clozaril, and in some cases, financial barriers that included budgetary restrictions that limited the number of patients who could be prescribed the medication.
- 4) NEPEC should continue to monitor the workload, allocation of resources, and quality of care indicators for mental programs with specific attention to substance abuse programs.

The committee's second annual report continued the above recommendations and included the following recommendations:

- VHA should staff CBOCs with health providers who can meet the special health-care needs of veterans whenever specialized services workload is justified.
- The Under Secretary for Health should be authorized to survey the clinical management at all psychiatric facilities consolidated within the past three years to determine the impact consolidations have had on the medical care provided at those facilities.
- That each VISN prepare a brief addendum to their business plans that addresses achievements in the transformation and the improvement of care for the SMI veterans they serve. At a minimum, this report should address closures of inpatient programs, the creation or expansion of outpatient programs, the percentage of inpatient resources reinvested in community support programs, and comments by consumers and consumer advocates prior to implementation of changes.
- That the national VA formulary specify the use of new antipsychotic medications in a manner consistent with the newly developed practice guidelines for the care of the seriously mentally ill. It is further recommended that the Network formularies establish rules for the use of these agents consistent with the national formulary and the practice guidelines.

The DAV has supported VHA in its efforts to make access to medication, supplies, prosthetic devices and other over-the-counter medically necessary supplies more equitable. However, we are now concerned that the National Formulary is too restrictive and impedes the delivery of medically sound health care by not allowing VA health care providers sufficient flexibility in meeting the health care needs of this Nation's sick and disabled veterans.

The DAV, as well as other veterans service organizations, believe that a moratorium on the VA's formulary is necessary. The moratorium should address clinical needs and outcomes as well as cost effectiveness of prescription medication, over-the-counter drugs, prosthetics and medical and surgical supplies.

We have requested that an independent analysis be undertaken in order to address the effects of the National Formulary on the quality of care being delivered by VHA to America's sick and disabled veterans.

Additionally, we ask that:

- VHA devote sufficient resources to establish more Blind Rehabilitation Outpatient services.
- Congress should specifically address legislation for workforce development or employment for homeless veterans.
- Congress should reauthorize the Sexual Trauma Act to include National Guard and Reserve sexual trauma victims access to VHA sexual trauma counseling.
- VHA monitor program activities and expenditures and provide appropriate technical training to personnel at VHA facilities, so that veterans' ability to receive high quality prosthetics and sensory aid services are not hampered by the reduced ability of the Strategic Health Care Group for Prosthetics and Sensory Aids, a national program operated by VHA headquarters.
- VHA clinicians must be allowed to prescribe prosthetic devices and supplies based on medical need, not cost.
- VA should explore the possibility of using military physicians from the Uniformed Services University of the Health Sciences in treating veterans with specialized services needs.
- Congress should enact legislation to require VHA as part of its health care benefits package the ability to provide institutional and non-institutional long term health care as part of its benefits package.
- We also ask that VHA improve its ability to monitor performance and to collect and publish data on the performance of each VISN against any proposal to collect and report only overall national data.

As you have heard here today, because VHA is undergoing massive changes that include deteriorating budgets, decentralization of health care decisions (22 VISNs versus one central office), consolidations, reliance on non-appropriated revenues and staffing shortages, health care is not being delivered as Congress intended.

Therefore, we ask that the management of all specialized services be centralized with additional staffing in order to ensure that these services be given the priority and monitoring intended when section 1706 was added to title 38, United States Code, on October 9, 1996, as part of Public Law 104-262.

This concludes DAV's testimony on the managing of health care and medical services as required under title 38, United States Code, section 1706. We appreciate the opportunity to present our views, and we thank this Committee for its continuing support of this Nation's veterans. I am willing to answer any questions that the committee might have.



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*A Not-For-Profit Veterans Service Organization Chartered by the United States Congress*

Statement of

**VIETNAM VETERANS OF AMERICA**

Presented by

**William Warfield**

Deputy Director of Government Relations

To the

**House Veterans' Affairs Subcommittee on Health**

Regarding

**Specialized Treatment and Rehabilitative Needs of  
Disabled Veterans**

July 23, 1998

1.

**Introduction**

Chairman Stearns, Ranking Member Gutierrez, and members of the subcommittee, Vietnam Veterans of America (VVA) is pleased to have an opportunity to present testimony about our views on the VA's mission to provide specialized treatment and rehabilitative needs for disabled veterans. We are especially interested in tracking and monitoring the performance-compliance requirements for management and health care directed by this committee in section 1706 (b) (1) of Public Law (104-262) .

VVA's priority is to verify that VA is carrying out the provision of services for severely and chronically mentally ill veterans. We are especially aware of the major changes in the delivery and treatment for medical care for veterans with illnesses such as Post Traumatic Stress Disorder, Substance Abuse and related conditions which are causing an increase in the numbers of homeless veterans. These changes have had a strong impact on the quality and standards of care and need to be carefully evaluated.

We commend the subcommittee for conducting this important oversight hearing. We are active members of the Advisory Committee on Care of Severely Chronically Mentally Ill Veterans required by sec 1706 (b) (2) of title 38,USC. We will address many of our concerns relating to how effectively the VA is following the legislative mandate in this law, and if consultation with two advisory committees is being followed as required by law.

We agree with you, Chairman Stearns and Ranking Member Gutierrez, and the other dedicated members of the health subcommittee, that it is important and timely to take a close measure and evaluation of the performance and compliance of the six special programs covered.

**2. Outcome Results and Performance Measurements- Mostly Trial and Error**

**Sharp Trends for Decline in Commitment to Veterans**

In our view, the most relevant requirement of Public Law 104-262, The Veterans Eligibility Reform Act of 1996, is the protection of specialized treatment needs for disabled veterans, and especially the explicit requirement which obligates VA to maintain national capacity and to meet the specialized treatment and rehabilitation needs for spinal cord dysfunction, blindness, amputations, serious mental illness, Traumatic Brain Injury, and Post Traumatic Stress Disorder. Homeless veterans and substance abusers who are disabled due to mental illness are included as seriously mentally ill. Prior to addressing the current state of the art and the specifics for VA's capacity, access, and outcome performance for these vital special needs programs, I wish to go on record and express the disappointment and frustration which veterans are experiencing with the current negative climate and standing with the federal government. These major and chronic disabilities, are all associated with individual courage and sacrifice in serving, defending, and protecting our country. This unique point has recently been forgotten by many government. Our moral and legal responsibility are now and always should be to provide the highest and best standards of care and treatment for veterans who gave so much in defense of America. That obligation must not be eliminated nor shirked by those who make our laws at the federal level, and those whose duty it is to enforce the laws. A strong perception and reality has surrounded this government like a deadly fog, that is part of the general lowering of the government's priority ranking for our veterans. This sad decline became reality when the majority in Congress and the President took scarce budgetary dollars of an estimated \$15 billion from disabled veterans and their widows and orphans to pay off high rolling transportation special

3. interest groups. Those of us who work every day to protect those who were wounded in the line of duty, must make our voices heard loud and clear by Americans who vote in November.

The ongoing trend of reductions in VA budget resources is especially troublesome for special needs programs. These programs, such as medical care for the seriously mentally ill, are costly and staff intensive. Because of the comparatively higher costs per patient, special-needs care, such as combat veterans with PTSD, are the first to have treatment reduced or eliminated. What will happen when the supply and quality of medical services for people who suffer from serious mental illness and related chronic conditions and reduced disability ratings are imposed by VA?

#### **VA's Performance Results for Special Needs Programs**

VVA, working in partnership and close cooperation with our good friends and colleagues other VSO's share information and monitor the quality of VA patient care. Our sources of information from the field include: VA Health Administration data on care, VSO service reps, and case reports from hundreds of veteran patients from every one of the 22 VHA networks and their medical care facilities.

In this case, we have carefully considered both the 1997 and 1998 reports to Congress submitted by the VA Secretary and Under Secretary for Health. We intend to devote the remainder of our written statement to our own comments, findings, and recommendations targeted for the most part on current conditions as we see them for three of the special needs programs; serious mental illness, Post Traumatic Stress Disorder, homeless veterans, and substance abusers disabled due to mental illness.

Our organization has devoted more time and attention to these special needs areas than

4. others, but we want to make it clear that we have the same concerns and support for all of the six disabling conditions .

#### **Serious Mental Illness**

As mentioned in the data highlights of the VA report submitted on June 8, 1998, to the committee, VA treatment of **seriously mentally ill patients** increased by one percent from FY 1996 to FY 1997. During FY 1996, 269,009 individuals were provided at least some form of care, and 272,229 received care for SMI in FY 1997. Total VA costs went down, from \$2,080,239,804 in FY 1996 to \$2,015,642,146 in FY 1997. Looking behind the raw data presented in the reports has allowed us to learn about some results that have produced unintended consequences. The reported numbers of patients getting treatment for mental illness at VA facilities looks good. More patients are being treated for less dollars. What could be better than that ?

The VA report data shows a much different pattern for the category of VA treatment those who are diagnosed as being seriously mentally ill with **substance abuse**. On a national basis: VA provided care for 107,074 unique veteran patients with substance abuse during FY 1996. By the end of FY 1997 there was a decrease in the number to 104,441. The cost data show a substantial reduction in VA costs for providing substance abuse treatment, from \$575,902,000 for FY 1996 to \$463,372,227 in all of FY 1997. Surely this indicator is good news. But does it mean that there were fewer numbers of patients treated, cost savings of over \$112 million in just one year ? This result should provide any managed health care system very high marks for performance.

The VA reported data for seriously mentally ill homeless individuals treatment tells us that in

5. FY 1996, VA treated 24,539 unique homeless veterans, and in FY 1997 the number increased to 24,613. Again desired goals were achieved with cost declines from \$75,071,096 in FY 1996 to \$72,764,874 for FY 1997. VA, as a more recent vintage managed care system, gets high marks for being able to provide more care for less dollars. In this category VA has achieved cost saving of \$2,306,222.

A final category of interest is the data reported for veterans with PTSD. This data continues to show the similar trends, with 39,653 veterans treated in FY 1996, increasing to 40,027 in FY 1997 PTSD patients treated. VA spent \$101,882,316 on PTSD in FY 1996 and \$95,222,722 in FY 1997. 444 more patients were provided health care for PTSD with savings of \$6,659,594 over the two year period. These impressive profit margins would result in high performance ratings by Wall Street stock brokers and financial planners if VA were listed on the New York Stock Exchange and was a private for profit corporation. The data as used to measure performance is both misleading and illusionary. VA's mission and purpose is not to make a profit nor to reduce the level and quality of health care for veterans and the laws directing its mission. No one knows this better than the men and women who serve on this committee and who are strong advocates for veterans.

We could not disagree any more forcefully with a policy which is driven in the wrong direction. These dollar- driven, bottom- line policies are producing adverse consequences nationally. And they are short changing veterans in every category, but they are especially harmful for veterans who are poor and who suffer multiple health problems related to mental illness. VA is not solely responsible for this retreat from our 200 year federal commitment to care for veterans. Other players like OMB/CBO have forced the VA budget into near starvation all in

6. the name of deficit reduction. But at what costs ? Should the health and well being of veterans be transferred to Blue Cross and Blue Shield, or Kaiser Permanente, or even state and local government ? We say a resounding **NO** to this. But the end result of consolidations, decentralization, and cost reductions is by default shifting the burden and responsibility for the care of veterans who earned that care to non-VA programs. Worse yet, those hardest hit are Veterans who once got good care and needed at least some inpatient support to receive therapy and vital medications . Longer term care on an inpatient basis at VA is a vanishing reality. And to make matters worse, many veterans are being harmed by other cost driven policies forced on VA which now results in often inferior and restricted medications imposed by cost driven use by the National Formulary Program. VA is using certain “academic and scientific studies” of limited and questionable value to rationalize shifting a major share of care and treatment for serious mental illness from inpatient to outpatient. Much more substantive valid, and especially independent peer review verification and research on this questionable theory of treatment, is needed. What we are seeing in our case management work for our members is that many of those who need the longer term psychological care and have benefitted from residential treatment, are being given only one option to “wait for the opening” for an outpatient appointment on a clinical basis only. It has been our experience that this policy has a very high probability of failure. Many veterans, when told by their nearest VA hospital or clinic to come back later for an appointment, drop out of the program completely. Many go to the streets and become homeless, many self medicate and become substance abusers, many end up in jails, too many die or become seriously ill from exposure on cold urban alleys.

We have confirmed that the numbers of homeless veterans is growing, in fact more that 275,000

7. veterans are estimated to be homeless on any given night of the year. Despite this shocking fact, less than 3% of all of the more than \$1 billion federal funds by HUD spent on homeless programs each year is made available to veteran homeless projects. The myth that the VA is meeting all of the needs for veterans is still pervasive, but wrong. We urge this committee to work

with us and other VSOs to do more in-depth impact field and case management studies to find out the true impact for these change. We urge you to help us look behind and beneath the hidden numbers provided by the agency and consider the impact on our veterans. We urge you to do this soon before more of us are lost.

The best way to get the truth is for you as representatives of your districts, to visit first hand VA hospitals, clinics, and vet centers in your home areas. Talk to veterans who use the VA health care system, talk to local health care providers who care for veterans, and talk to the VSO service reps. who have great insight. Make your own studies, conclusions and fact finding missions. Listen to the real people back home and discount most of the inside the beltway spin that is constantly fed to you here.

#### **Conclusion**

We ask your assistance in helping us to explain to our rank and file members why our National Government denies care and benefits to veterans and their wives and children at a time when new federal budget estimates made by The Congressional Budget Office state that "federal revenues will outpace federal spending by \$520 billion through 2003". Vietnam Veterans of America (VVA) appreciates your strong advocacy and support for veterans.

Ending on a hopeful future outlook, we wish to express our admiration, respect and appreciation to Dr. Kizer, Dr. Horvath, Dr. Batres, Dr. Lehmann and the other outstanding staff

8.  
at VHA. Despite our differences of opinion sometimes on policy goals and direction, they are always accessible and open to our comments and suggestions. VVA continues to remain encouraged about the progressive and forward progress we are encouraged to make by VHA leaders in seeking cost effective and workable innovations for treating PTSD. We hope to be able to share with you soon our cooperative work on developing improved counseling on an inclusionary basis for and with families of veterans. VA remains very positive with our outreach program to connect and bond with hard to reach veterans who live in remote rural areas of the country, and especially Native American Veterans.

This concludes my statement, and I will be pleased to answer any questions.



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Warfield reports to the VVA director for government relations and is responsible for budget and appropriations legislation. In addition he serves as the VVA representative to the Department of Veterans Affairs /Veterans Health Administration-VSO liaison committee on health care issues.

Bill Warfield received his B.S. degree in Economics from the University of Maryland. And served honorably for four years in the United States Air Force. He resides in Rockville, Maryland, with his wife Ellen. The Warfield's have two daughters Abbie and Amy and six grand children.



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### **VIETNAM VETERANS OF AMERICA, INC.**

#### **Funding Statement**

**July 23, 1998**

The national organization Vietnam Veterans of America, Inc. (VVA) is a non-profit veterans membership organization registered as a 501(c)(19) with the Internal Revenue Service. VVA is also appropriately registered with the Secretary of the Senate and the Clerk of the House of Representatives in compliance with the Lobbying Disclosure Act of 1995.

VVA is not currently in receipt of any federal grant or contract, other than the routine allocation of office space and associated resources in VA Regional Offices for outreach and direct services through its Veterans Benefits Program (Service Representatives). This is also true of the previous two fiscal years.

**For Further Information, Contact:**

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# BLINDED VETERANS ASSOCIATION

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**THE HOUSE COMMITTEE ON VETERANS' AFFAIRS  
SUBCOMMITTEE ON HEALTH  
OVERSIGHT HEARING  
JULY 23, 1998**

**STATEMENT  
BY  
THOMAS H. MILLER**

**EXECUTIVE DIRECTOR  
BLINDED VETERANS ASSOCIATION**



Mr. Chairman and Members of this distinguished Subcommittee, on behalf of the Blinded Veterans Association (BVA), I want to thank you for the invitation to participate in this most important Oversight Hearing. As you may recall, in our annual Legislative Priorities presented before the Joint Session of the House and Senate Committees on Veterans' Affairs last February, we called for such an oversight hearing. We trust this hearing will assist this committee to determine whether VA is living up to the mandates of the Eligibility Reform Act of 1996. BVA is especially concerned with the provision contained in Section 1706 of Title 38 USC requiring the VA to maintain its capacity to provide rehabilitative services to disabled veterans.

This is a particularly good time for this hearing. VA is celebrating the 50th Anniversary of both the Blind Rehabilitation Service and the first Blind Rehabilitation Center located at the VA Hospital Hines, Ill. The concept of a comprehensive residential blind rehabilitation center was developed, refined and expanded providing VA with the foundation for its outstanding service delivery system for blinded veterans. This approach provides blinded veterans with the opportunity to achieve acceptance of and adjustment to the loss of vision while at the same time acquiring the necessary adaptive skills to overcome the handicap of blindness. We are concerned, as the Veterans Health Administration (VHA) completes its transition from acute hospital based health care to outpatient managed primary care, just how the residential program will survive. The overarching issue seems to be cost savings. Inpatient programs are viewed as unnecessary, expensive programs. Further many VHA officials and Network Directors cannot understand why blind rehabilitation services cannot be provided on an outpatient basis. This notion is clearly cost driven and fails to recognize the intrinsic value of the residential approach and the depth to which it is able to accomplish so much to restore a blind persons self esteem, worth and confidence.

The reason this model is so successful is because the blinded veteran is totally immersed in a completely therapeutic environment. The center based program provides the veteran the opportunity to live twenty four hours a day seven days a week with others who are experiencing the same problems, anxieties and fears. This opportunity to share this common experience contributes mightily to the adjustment phase of the program. The expectations for the blinded veteran are also totally different from those in the community or even the family. Family members as well as the community as a whole expect little from a blind person and tend to be over protective and not allow that individual the space and opportunity to develop functional independence. From the moment the veteran arrives at the BRC, he/she is expected to become independent and do many things for him/herself. For example it is expected each student is responsible for getting to all meals and classes independently, to maintain his/her room including making the bed daily and changing linens weekly. The beauty of this program however, is that nothing is expected that the vet has not been trained to do and is fully capable of managing independently. The key to the effectiveness is the program builds on small successes initially and with each achievement new and more difficult challenges are progressively added. The veteran is never required to accomplish any task without the appropriate training and preparation.

Before delineating BVA's recommendations associated with the existing system and local problems, I want to describe in some detail each of the specialized services provided by VA for blinded veterans. This understanding is crucial to evaluating the appropriateness of

management decisions effecting these programs. The Eligibility Reform legislation referred to above has just that provided a uniform package of benefits for enrollees with strong emphasis on primary and preventative care. BVA fully supported the need for the ERA and believes strongly in timely access to preventive care for all veterans. Likewise, we strongly supported Dr. Kizer's "Vision For Change" and his subsequent "Prescription for Change" and "Journey for Change." BVA recognized the need to change the direction of VA health care and the fact it could no longer maintain its hospital based approach. In addition to not being economically viable, it was not the most efficient and effective means of delivering quality health care. Conceptually, this new delivery model should provide veterans with greater access to high quality timely services.

Dr. Kizer's concept of adopting managed care principles proven successful in the private sector seems to make good sense for the VA system. BVA remains skeptical as to how the special disabilities programs, particularly those that are inpatient based, will be integrated into the managed primary care model. The private sector has no such model. If they provide the service at all, they are forced to contract for these specialized services. There is no doubt this is because of the cost involved to operate such programs. The challenge for VA therefore is to identify some method of integrating these costly special programs into a less costly system of care. Some have questioned, including Dr. Donald Custuss former Chief Medical Director for VA Department of Medicine and Surgery, the need for VA health care if the VA does not support and provide high quality special disability programs. BVA joins those who believe these specialized programs are in fact the very essence of VA.

The new VHA seeks to accomplish this objective with the development of a new resource allocation methodology that attempts to more equitably distribute funds across the system. Two reimbursement categories of funding have been created to account for the high cost of the special disabilities programs. One category for basic care and the second a much higher rate for the special disabilities programs. Theoretically the Veterans Equitable Resource Allocation (VERA) model should adequately fund these specialized programs. Initial reactions to this model in the field were very favorable. Managers immediately viewed this special reimbursement rate as a potential windfall and a real money maker for the host facilities. They have learned however to really make money it will be necessary to reduce the number of bed days of care or the length of stay for veterans admitted to these more expensive programs. Since the special reimbursement rate is based on a national average for special programs, budgeteers have determined there must be a point beyond which the patient will cost more than the reimbursement rate. The number of these types of patients must be kept to a minimum if the program is to be cost effective.

Mr. Chairman we are deeply concerned over the constant pressure being imposed on the Blind Rehabilitation Centers (BRC) to reduce the length of stay for blinded veterans receiving residential rehabilitation. The length of stay has in fact declined substantially over the years as a result of the changing needs of the veteran population being served by these programs. Additionally, the BRC managers have made concerted efforts to identify achievable efficiencies that might result in shortened programs without compromising quality. BVA believes these efforts have been largely successful and consequently additional mandated reduction would be detrimental to the overall objectives of the program. We have received reports from nearly every BRC suggesting further reductions are expected.

The pivotal issue seems to be determining how long should an episode of blind rehabilitation take? Unfortunately, there is no one size fits all program. The strength of the VA program has always been its ability to tailor the program to meet the individual needs of any given blinded veteran. Many variables must be factored into any determination regarding the length of a program. Any individual confronted with vision loss, whether it be sudden and traumatic or gradual, must first learn to accept and adjust to this loss and then acquire the essential adaptive skills necessary to achieve maximum independence. Each of us reacts differently to stress, trauma or significant loss of independent functioning. There is no scientific measure to predict how each veteran will respond to blindness and therefore just what kind of a rehabilitation program would maximize his/hers functional independence. Moreover, there are no readily available predictors of how long a rehab program should take for each veteran. Each of us learns at a different pace, has greater or less potential to master the necessary adaptive skills and how much repetitious training is necessary for that individual to in fact obtain sufficient competence and proficiency with the essential adaptive skills and techniques necessary to develop the confidence required to optimize independent functioning in the home environment varies widely from veteran to veteran. The reality of functioning independently without the security of knowing a specially trained instructor is with you in the event you experience frustrations or difficulties is a great source of anxiety for many of us upon completion of the rehab program. If the program is artificially shortened eliminating the opportunity for the development of confidence, the veteran will either not use these skills after returning home or will likely utilize them inappropriately.

I am pleased that VA BRS is aggressively developing a blinded veteran register. This register will contain substantial data regarding a veterans rehabilitation program and outcomes achieved with demographic data. This data will hopefully allow blind rehab professionals to begin to develop profiles of which blinded veterans benefit most from what types of services. We do not question that not all blinded veterans need a comprehensive residential rehabilitation training program. Some segments of our population could very well have their needs satisfactorily addressed by outpatient services delivered in their home areas or even some other form of intervention. All these decisions are dependent upon the degree of visual loss, the veteran's emotional and psychological adjustment status and the extent of the needs for which the veteran seeks assistance. There is no doubt, given a sufficient comprehensive data base, such profiling could be achieved. Ideally, therefore, a newly identified blinded veteran could be matched to the profile and a decision could be made regarding the most appropriate treatment modality to address rehabilitative needs.

Mr. Chairman, I am pleased that Blind Rehabilitation Service is making significant strides to developing just such a blind veteran registry with the potential to formulate profiles to assist in determine the most appropriate model for care. This process will take time and must be done with care to insure that data entry is accurate. With respect to BRS, Dr. Kizer's vision of a VHA as a system characterized by data driven management decisions and outcomes can be realized. With respect to blind rehabilitation, adequate data does not exist at this point for facility or Network managers to make substantive programmatic changes. BVA believes very strongly a moratorium be placed on any such programmatic changes until sufficient data is available upon which decisions can be based. Blind Rehabilitation Service is progressing nicely

with the development of Outcome Measurement Instruments to collect this valuable data. Several of these discipline specific instruments are currently being tested while others remain in the development phase. Following testing, the instruments must then be refined and validated. Once this process has been completed, reliable data can then be collected analyzed and utilized in evaluating the value and benefit of the program or model of intervention effecting the desired outcomes. The bottom line, Mr. Chairman, is clinicians with substantial involvement of the veterans must determine the scope and length of the residential training program. If the expressed purpose of the VA special emphasis programs is to maximize functional independence and enhance the quality of life for the disabled veteran, programmatic decisions must be made by clinicians not budgeteers or number crunchers. If the reverse is allowed to drive the system, then VA special programs will certainly suffer. In fact, they will be no different than the private sector Health Maintenance Organizations (HMO) that allow administrators, rather than clinicians to make medical decisions determining what kind and when care will be provided. We have heard enough of these horror stories to know that is not that direction VA should be taking. Mr. Chairman, it is important to place Blind Rehabilitation Services within the context of a full continuum of care for these severely disabled veterans. In addition to basic health care, VA offers three separate program approaches to deliver comprehensive services to blinded veterans. Given the new direction of VHA as described above, basic health care is defined as preventive managed primary care. When a veteran enters or enrolls in the VA health care system, he is assigned to a primary care team for the assessment and management of his medical needs. For the past thirty years, the blinded veterans access to the VA health care system has been the Visual Impairment Services Team (VIST). This is a multidisciplinary team approach to the delivery of comprehensive services. The establishment of the VIST resulted from a pilot project initiated by VA in conjunction with the American Foundation for the Blind (AFB) and BVA. VIST is an aggressive outreach approach to the delivery of essential services made necessary by the fact that blinded veterans were not taking advantage of the programs and services to which they were entitled. The principle cause for the phenomena is the isolating effects of blindness.

The interdisciplinary team approach to service delivery proved highly successful with respect to blinded veterans. As the VA gained experience with this new approach, it quickly became evident the success of the team approach was directly dependent upon the Team coordinator. In the very early years, the VIST coordinator was an individual team member, normally the social worker, who was assigned the coordinator duties on a part time basis. The rapid success of the program dictated that the Coordinator position be converted to full time if the growing work load were to be effectively managed. Thanks to Congress, additional full time positions were provided and the numbers of full time VIST Coordinators have grown dramatically over the years.

The extraordinary success of the VIST program has resulted in the development of knowledge absolutely vital to the delivery of relevant services to blinded veterans. These services are not limited to health issue but include in-depth knowledge of the VA compensation and pension benefits programs as they relate to blindness, prosthetic and sensory aids essential to overcoming the handicap of blindness and achieving functional independence, individual and family counseling around adjustment to blindness issues and familiarity with local agencies and programs, if they exist, that provide services for the blind. Additionally, these Coordinators are

intimately familiar with the VA Blind Rehab program and have developed the necessary skill to properly educate veterans to the advantages of residential blind rehabilitation and possess the capacity to motivate these individual for referral when appropriate. The Coordinator must also possess knowledge and understanding of other federal programs, such as Social Security Disability Insurance (SSDI), and provisions of the Internal Revenue Service (IRS) code that apply to the blind. As you are well aware, these programs are complicated at best and become even more so when trying to understand provisions that have special application for the disabled. Mr. Chairman, I have outlined the full scope of the knowledge and responsibilities of the full time VIST Coordinator because there have been, and we fear ongoing, efforts to eliminate these positions as full time. At least four facilities, when a full time position became vacant, have eliminated the full time position and reassigned those duties on a collateral basis to an existing staff social worker. After the intervention of Deputy Secretary Gober, however, two of those facilities reconsider their decisions and have in fact again filled those positions on a full time basis. It appears that the other two facilities, both in Network 9 have ignored the interest of Mr. Gober and believe they do not have to be responsive to Headquarters with regards to local decisions.

Although only two positions have been eliminated at this time, we are deeply concerned that should this type of local autonomy with respect to the special disabilities programs be permitted, it will not be long before other Networks ignore national program guidelines or policies.

Dr. Kizer has frequently advocated for a case management approach to the delivery of health care services. BVA believes the VIST program epitomizes just such an approach. The full time Coordinator is indeed the case manager for all blinded veterans in their service area. Additionally, we do not believe VIST conflicts in any way with the managed primary care with respect to blinded veterans health care needs being managed by a primary care team. We do object however by any attempt by local management to suggest the primary care team can be substituted for a full time coordinator. This is precisely the approach management in Network 9 is taking. The primary care team only serves as another valuable resource to the VIST Coordinator to address blinded veterans needs.

Before continuing with a description of the crucial special programs for blinded veterans, I would like to take this opportunity to expand on the above observation regarding the practices of Network with respect to national programs and any perceived intervention on the part of Headquarters and or its program officials. BVA has repeatedly expressed concern over the decentralization of decision making to the local or Network level when it come to the special disabilities programs. While decentralizing decision making to the lowest possible level may be appropriate for the provision of basic health care, we do not believe this to be the case for special programs. Local decision makers have demonstrated a strong desire for autonomy and feel that any involvement on the part of Headquarters program officials as unwanted interference. Many seem to believe they possess the exclusive right to determine the future of these programs and how they will be administered and provided regardless of the impact on quality. Few, if any of these managers, possess the professional knowledge, expertise or experience in the provision of services for the blind. Cost savings seem to be the only program they understand. If the special

disabilities programs are to be successfully integrated into the new VHA Network concept, the management arrogance that exist in the field must be replaced by the willingness to work cooperatively with program officials to identify solutions or new approaches to service delivery that satisfy both the need to preserve quality while at the same time finding reasonable cost savings.

Returning to the description of special programs for blinded veterans, one might ask how does a blinded veteran find out about and gain admission to a VA comprehensive residential BRC? As mentioned previously, the blinded veteran's access to the VA health care system and it's full array of services, is through the VIST program. Following extensive evaluation and assessment, the VIST coordinator, if determined to be the rehab plan of choice, will initiate a referral to the appropriate BRC. During this process, it is important to understand the BRC is only one of an array of services or resources available to the Coordinator to address the blinded veterans identified needs. The BRC is only one of many on the continuum of care, no different than ophthalmology, neurology or dermatology. The coordinators responsibilities do not end here. In many cases contact with the blinded veteran must be maintained during what can be a long waiting time before admission to the BRC. The blinded veteran's motivation may be marginal at best when referred and needs to be reinforced during the prolonged waiting period. Blinded vets have extreme difficulty in accepting the importance of leaving home to attend the residential programs because of negative attitudes about blindness and skepticism regarding any positive improvements resulting from rehabilitation. Periodic contact with the blinded vet on the waiting list by both the VIST Coordinator and the BRC has proven effective in providing the necessary reassurances and support to prevent the veterans withdrawal from admission to the program.

The final specialized service for blinded veterans along the continuum of care is the Blind Rehabilitation Outpatient Specialist (BROS) program. This is a new and innovative approach to the service delivery not available from VA until approximately two years ago. The BROS is a blind rehabilitation specialist who is ideally dual certified with two Masters degrees in Orientation and Mobility and Rehabilitation Teaching. These are the professional degrees received from University teacher preparation programs for rehab professionals working with the blind. Should dual certified rehab professionals not be available, VA then selects an applicant with one or the other Master degree and provide extensive cross training in all discipline specific areas of instruction within the blind rehabilitation service.

The properly credentialed BROS is qualified to provide outpatient blind rehab services to the veteran in the home environment should this be the most appropriate method of intervention. This was not possible in the past and now completes the full range of resources and services available to the Coordinator to meet the needs of blinded veterans. The BROS is now a local option for service delivery for those veterans for what ever reason will not be able to attend a residential BRC. Additionally, the program has been designed to provide pre and post rehabilitative services to blinded veterans accepted for and awaiting admission to a BRC. Conceptually, if blind rehab services can be provided prior to admission, this will reduce the length of stay in the residential program. Similarly, if a veterans residential program can be completed by the provision of remaining skill acquisition in the home environment, this also may

reduce the length of stay. At the very least, the BROS can conduct follow up in the local area for the BRC to determine if the blinded vet has successfully transferred the skills learned at the BRC into his activities of daily living.

Unfortunately, Mr. Chairman, there are only 15 such positions across the system. Outcome measurement instruments are also under development by BRS. Once they have been tested, refined and validated, information instruments generated will be an extremely valuable addition to the data base. Network directors and local facility managers seem to believe that data generated from this alternative approach to service delivery, the outpatient rehab services, are the answer to the high cost of blind rehabilitation. It should contribute significantly to the ability to profile blinded veterans with respect to employing the most appropriate rehab model. Fifteen positions may not generate enough data to be statistically significant for the purpose of the profiles.

Hopefully, the description and discussion to the array of essential programs especially designed by VA to address the unique needs of our blinded veterans, will help to place our recommendations below into proper perspective. Before outlining our recommendations Mr. Chairman, I want to reiterate BVA's unwavering support for a strong Prosthetics & Sensory Aids Service. The ability of any blinded veteran to successfully overcome the handicap of blindness is directly dependent on access to and proficiency with specially adapted sensory aids and appliances. Timely access is especially critical given our dependence on adaptive equipment for functional independence. Delays, even those that seem insignificant to an able bodied persons, can be devastating to severely disabled veterans. Adequate funding for and an efficient delivery system for these services is absolutely essential if disabled veterans are to maximize their functional independence and experience quality of life comparable to their able bodied contemporaries.

BVA is gravely concerned over the projected short fall in funding for prosthetics for the remainder of this fiscal year and the potential impact on blinded veterans. The alarming changes occurring in Prosthetics & Sensory Aids Service in the field are also very disturbing to BVA. The organizational realignment or elimination of these services will certainly result in diminished timeliness and quality of service. BVA has long supported centralized funding for PSAS and continue to believe this methodology is the most effective for the long term survival for the provision of these essential services.

BVA suggests the following recommendations for consideration as possible solutions to problems inherent in the new VA delivery system.

1. Prosthetics and the special disabilities programs are national programs and must be treated as such. These vital programs cannot be allowed to be fragmentate into 22 different systems of service delivery voids of uniformity and consistency of service delivery. National Standards and Guidelines must be developed and promulgated across the system. Adherence to these published standards and guidelines should be mandatory. Sufficient flexibility can be

incorporated into those standards to permit innovation and creativity at the local level. Basic models of rehabilitation must be preserved however, until such time as alternatives can be supported by outcome data.

2. The VA ability to measure capacity with respect to the special programs is currently inadequate. The Information Management System (IMS) does not currently possess the necessary degree of proficiency to capture accurately essential data. Although moving in the right direction, VHA has not fully implemented necessary state of the art technology. Additionally, the organizational alignment of these specialized services at the local and Network levels does not facilitate rolling up accurate national data. Including the confusion generated by having these programs aligned under a variety of product lines classifying beds differently, facilities and Networks code admissions differently along with costing services to BRC differently. In the Capacity Report submitted early this year to this Committee, VHA is comparing apples with oranges when it comes to data provided to demonstrate BRS is maintaining capacity. The overall numbers do not differentiate between BRC, VIST or BROS. Consequently, it is impossible to determine if VA is maintaining capacity to provide comprehensive residential blind rehabilitation services. Clearly, we believe, VIST and BROS are vitally important programs but by design they are outpatient services and should be included into the inpatient mix. Increases in VIST or BROS numbers can offset decreases in BRC episodes of care leaving the impression there has been no reduction of capacity.

Similarly, the manner in which data regarding staffing levels in the special programs is flawed. Costing practices at various facilities distort the figures. Many ancillary services are charged to the BRC program again distorting the total numbers of FTEE dedicated to the provision of rehabilitative services. We do not object to charging these other services that are necessary for the provision of necessary rehabilitation but we do strenuously object to not separating out those blind rehabilitation specialist positions involved in direct daily rehab service FTEE. Without rehab staffing composed of sufficient blind rehab specialists, VA cannot maintain its capacity to deliver these specialized services. Failure to separate teaching or instructor positions from ancillary services in reports, can prove very deceiving in terms of measuring capacity.

The other important issue that must be considered when evaluating maintenance of capacity is bed days of care. The proposal to close 15 beds at the VAMC West Haven, Conn. argued that reduced lengths of stays enables the facility to process more blinded veterans through the program thus maintaining capacity. They believe if they can rehab the same number or more with fewer beds they have not diminished capacity. Mathematically, this may make sense, but the opportunity to receive quality rehabilitation will be severely compromised. The length of stay will not be long enough to realize the outcomes described in detail earlier in this statement. Veterans like others, cannot be forced to adjust more quickly or to gain proficiency in utilizing adaptive skills. The confidence that only results from the proficient application of adaptive skills cannot be accelerated or imparted by means other than careful instruction and practice. For these reasons, sheer numbers of blinded veterans admitted and discharged from a BRC should not be considered a viable measure of capacity. This production line mentality will spell the demise of VA residential blind rehabilitation

3 Prosthetics and the special disabilities programs should be centrally funded and managed. Despite the intent of the VERA to distribute funds equitable across the system, the special programs are not faring well. The fiscal burden continues to fall on the host facility. The special programs such as blind rehab, are not local but regional in scope. They serve multiple Networks and facilities. Consequently, the entire service area should share in support of these programs relieving the host facility of that burden. Currently a host facility is experiencing budgetary problems, such as many FTEE, they implement across the board reductions or freezes. Therefore, the BRC is forced to share in resolving these overages. Centralized funding would relieve the host facility of full financial responsibility for these programs affording greater opportunity for stable staffing patterns. Without appropriate staffing levels within the special programs, it is more likely the length of stay will be longer. Shortages of staff prevents efficient operation often causing a veteran's classes to be canceled due to unscheduled annual or sick leave. Consequently, it takes a veteran longer to complete the training. Adequate staffing levels provide BRC managers the flexibility to cover training in the event of either planned or unscheduled leave of any staff member.

4. The full implementation of VA IMS must be completed before reliable capacity data can be produced. It is imperative national standards and guidelines be established and enforced regarding classification of beds, coding and costing of services. This is another example of how centralized funding and management would improve the data collection process once IMS systems are in place. At the very least, FTEE at the Network level and in the Headquarter program offices must be tasked with and held accountable for the collection of uniform, reliable accurate data. Facilities and Networks must all report uniformly and consistently if an accurate representation of service delivery is to be obtained. To this end, this process may be facilitated by placing the special disabilities programs in their own service lines at the VAMC and Network level.

5. Facility, Network and Headquarters program officials must be held accountable for substantially improved communications and cooperative efforts to find appropriate solutions to areas of mutual concern. Failure to exchange relevant programmatic information can only result in blinded veterans not having access to the most appropriate services to meet his rehabilitative needs.

6. Unreasonable pressures to reduce the number of bed days of care in the absence of supporting data must be discontinued. Certainly BRC managers should be challenged to identify efficiencies wherever possible effectively eliminating unnecessarily prolonged rehabilitative episodes.

7. Steps should be initiated to assess the extent of waiting lists and admissions times for the nine blind rehab centers around the system. Out information suggests a wide disparity between waiting times from facility to facility. Significant improvements have been realized in waiting times in recent years in all but three or four centers. The BRC located at VAMCs Birmingham, Augusta and San Juan continue to have long waiting periods for admission. The assessment should consider the adequacy of resources at these facilities for the provision of blind rehab. Resources here should be interpreted to mean space and FTEE.

8. The ongoing efforts currently underway at the Rehabilitation Research & Development Center located at a VAMC Decatur, in support of the BRS effort to develop outcome measurement instruments should be encouraged and additional resources provided if necessary. It is important to note here that this collaborative effort includes private sector participation. Private agencies are providing outcome data to the RR&D Center for inclusion into the VA outcome database. This will enable VA to compare itself with the private sector or vice versa. Like the VA, the private sector is having its performance evaluated based on outcomes. In the field of blindness, little such data is available. Once again, this provides VA with the opportunity to take a leadership role in the field of blindness and provide invaluable lessons and service to all agencies providing services to blind Americans. Since the establishment of the first blind center at VA Hospital Hines, VA has been and continues to be recognized internationally as the premier provider of comprehensive residential blind rehabilitation services and the leader in the development of high quality services for the blind. To insure VA maintains this position of leadership, a regular review of VA programs and services for blinded veterans should be developed to include local, Network and Headquarter's program officials as well as relevant stakeholders. BRS contributes significantly to the overall VA mission of providing educational opportunities for health care professionals. In fact, pioneer members of the Hines Blind Center were responsible for establishing the graduate program for blind rehabilitation specialist at Western Michigan University. Hundreds of graduate students have completed internships at VA Blind Rehab centers and upon graduation have been hired to fill positions in VA blind rehab.

9. Finally, Mr. Chairman, BVA is extremely concerned over the inconsistent or total lack of access Category C. blinded veterans have to the system. Specifically these veterans do not have the opportunity to receive comprehensive residential blind rehabilitation. BVA understands the new enrollment system and the seven priorities of care but where work load permits, we believe more flexibility should be demonstrated with respect to the "Category C" blinded vets.

Some BRC do except these veterans even if only on a limited basis. For example, one BRC maintains a short notice list including the "Category C" vets. These veterans have indicated they are prepared to be admitted on very short notice should the BRC experience a last minute cancellation or premature discharge. Another BRC that recently had virtually eliminated its backlog for admission refused to admit "Category C" vets arguing they are able to maintain the required 85 per cent occupancy rate. Access to VA BRC is the only real opportunity available to these veterans to receive the necessary high quality services so essential to overcoming the handicap of blindness referred to above. If they cannot receive these services from VA they likely will not receive them at all.

This would appear to be a win win situation for both the VA and the blinded veteran. These veterans are prepared to pay the necessary co-pays and per diem payments required by VA and in many cases have private insurance from which the VA would be able to collect. It only makes sense to provide these blinded veterans with access to rehabilitation when workload permits. The host Network is reimbursed by VERA at the high rate for "Category C" veterans in the special rate group and therefore the Network or medical center receives the full reimbursement plus the co-pay and insurances when applicable.

Mr. Chairman, I have identified a number of serious problems confronting the delivery of comprehensive services to our nation's blinded veterans. There is no question appropriate solutions can be found if afforded the proper priority. BVA readily acknowledges these special programs and services are expensive, but absolutely necessary if blinded veterans are to have a reasonable opportunity to overcome the handicap of blindness and lead meaningful and productive lives.

That concludes my testimony Mr. Chairman. I will be pleased to answer any questions you or the subcommittee may have.

**STATEMENT OF THE  
AMERICAN PSYCHIATRIC ASSOCIATION  
ON MAINTAINING CAPACITY TO PROVIDE  
FOR THE SPECIALIZED TREATMENT OF  
DISABLED VETERANS**

**SUBCOMMITTEE ON HEALTH  
COMMITTEE ON VETERANS' AFFAIRS  
U.S. HOUSE OF REPRESENTATIVES**

**JULY 23, 1998**

The American Psychiatric Association is a national medical specialty society, founded in 1844, whose 42,000 physician members specialize in the diagnosis and treatment of mental and emotional illness and substance use disorders. We are pleased to be able to provide comments on the Department of Veterans Affairs (DVA) efforts to maintain its capacity to provide for the specialized treatment of disabled veterans, including those disabled by mental illness, consistent with P.L. 104-262.

Before commenting on the DVA's compliance with P.L. 104-262, we would like to first congratulate Members of Congress for ending discrimination in health insurance for veterans that suffer from mental illness, including substance use disorders. P.L. 104-262, the Veterans Eligibility Reform Act, makes no distinction between veterans receiving medical treatment for mental illness, including substance use disorders, and physical illness. We applaud you for ensuring that veterans receive the same access and level of coverage for mental disorders as physical disorders. We also commend the Veterans Health Administration (VHA), under the leadership of Under Secretary for Health Kenneth Kizer, M.D., for its strong support for parity in mental health care.

The VHA is going through a turbulent time as it moves from a hospital care system to a unique health care system. Efforts are underway to develop cost savings and improve access to care for all veterans, while remaining committed to meeting the needs of specialized veterans. The American Psychiatric Association supports the reasonable reorganization of the VHA, including the deinstitutionalization of the chronically mentally ill and the establishment of community-based programming to serve these veterans. But, maintaining treatment services to disabled veterans during times of change is critical. Because of the complex and chronic nature of most mental illnesses, a full continuum of care is needed to serve severely mentally ill veterans. It is critical for the VA not to lose sight of the need for a full continuum of care for veterans with mental illness. Dr. Kizer has assured our members that mentally disabled veterans will not be left behind in the new VA health system.

We are concerned about specialized programs with the VA's reorganization into 22 relatively autonomous service networks. Even under the central guidance of Dr. Kizer, there is a significant risk of inequalities in access and quality of care across the Veterans Integrated Service

Networks (VISNs). According to our members, as some VISNs are facing funding decreases under new resource allocation guidelines, resources are already being diverted from mental health, especially alcohol and drug treatment programming, at some VISNs. Other VISNs have been reluctant to make needed improvement in mental health treatment and have made little progress in establishing community-based programs for the mentally ill veteran. Further, some still attach significant stigmas to mental and substance abuse disorders, despite contrary policy and direction from the DVA in Washington. However, other VISNs are able to balance the need for access to mental health services with decreasing costs in an effective manner. The American Psychiatric Association is very concerned about the variations in services VISN to VISN for disabled veterans.

While the VHA works to correct the VISN to VISN disparities in care, the American Psychiatric Association asks them to urge VISNs to utilize psychiatrists in their planning process. Effective management of a health care system cannot be done solely by administrators. Many networks have done an excellent job in working with their mental health staff and consumers in the strategic planning process. These networks have been able not only to improve access to care but at reduced costs and have given early indications of improved outcomes. Unfortunately, other networks exclude psychiatrists from the planning process or disregard their advice and instead focus only on cost savings. Further, and even more disturbing, our members have indicated that there are VISN directors that still do not see mental illness, particularly substance abuse and addiction, as chronic diseases. Such ignorance must be corrected. We urge the VA to take the necessary steps to correct the wide variations in mental health services, VISN to VISN, and to urge the inclusion of psychiatrists in the mental health care planning process.

Overall, we commend them for the steps already taken to safeguard specialized programs and urge their continued progress in serving the needs of the veteran disabled by mental illness. Again, we thank the Committee for allowing the American Psychiatric Association the opportunity to provide comments on the DVA's compliance with P.L. 104-262.

## WRITTEN COMMITTEE QUESTIONS AND THEIR RESPONSES

DEPARTMENT OF VETERANS AFFAIRS  
Veterans Health Administration  
Washington DC 20420

In Reply Refer To:

August 14, 1998

The Honorable Cliff Stearns  
Chairman, Committee on Veterans' Affairs  
Subcommittee on Health  
House of Representatives  
Washington, D. C. 20515

Dear Mr. Chairman:

During the Subcommittee's July 23, 1998 hearing on VA's implementation of Section 1706 of Title 38 USC, you requested that I inform the Committee what steps VHA would undertake to respond to issues that were raised by the GAO and the Veterans Service Organizations in their testimony.

We remain committed to meeting the specialized needs of veterans who rely on VA for their care. Reports to Congress, in May 1997 and June 1998, detailed our efforts to measure the capacity of selected special programs. The first report established definitions of the programs involved and definitions of how we would measure 'capacity' and 'access'. Basically, capacity is measured by patients treated and dollars expended and access is measured by timeliness of service. The June 1998 report explains the challenge that we face in creating these measures and having comparable data from 1996 to the present.

In the last three years, we have made significant progress in restructuring VA healthcare. The changes made during that restructuring have added to the difficulty in measuring any change in capacity. To measure change, one needs data points that were available on October 9, 1996 and are still valid and available today. Despite the complexities underlying the measurement of 'capacity' and 'access', we believe that we are meeting the intent of the law. However, we are working to develop improved outcome measures for each of the special disability programs.

We are currently planning the following actions to address the concerns we heard during the hearing:

- Data: We will conduct a data summit later this year that will focus on resolving issues that have arisen due to the use of multiple data sources and ways of interpreting data. We intend to invite broad participation from those outside the VA who depend on our data to track quality and system improvements (VSO's, GAO and IG).
- SCI/D: VA will continue to work with PVA in developing outcome measures for patients with spinal cord dysfunction. However, concerns about our capacity to meet the needs of spinal cord injured patients have been raised and we need to resolve them. Accordingly, we will contract for an outside consultant study of our Spinal Cord Injury/Dysfunction program to look at capacity and quality. We are also increasing the priority scoring factors for construction projects that substantially support specialized programs. This will give special preference to projects supporting all of the special programs including SCI/D.

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## The Honorable Cliff Stearns

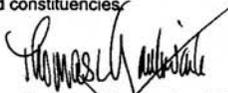
**Blind Rehab:** We will appoint a 'gold ribbon panel' to help us review VA's services for blind veterans and recommend ways to improve the integration of these services within our decentralized network structure and to serve additional visually impaired veterans.

**Prosthetics:** We are concerned that an increase in workload has resulted in a gradual increase in delayed orders. We have taken specific actions to address this issue including staff adjustments, central earmarking of funding, and continued careful monitoring of delays. We also plan to contract for a management study of our Prosthetics and Sensory Aids Service including the associated data questions to assure that the issues raised during the hearing are resolved.

**Mental Health:** We have previously mandated an assessment of the appropriateness of providing mental health services at all new community based outpatient clinics. We will task our Chief Consultant in Mental Health to work with the Networks to develop standards and assessment tools for community case management. It is anticipated that this effort will lead to guidelines and performance measures in the area of outreach and continuity in mental health.

**Performance Monitoring:** We have targeted specialized programs in our performance measurement systems and will continue to do so in the future. For example, our 1997 Network Performance Agreement Report contains measures for SCI/D patient satisfaction, assessment of addiction severity, and screening for alcohol abuse. We continue to review performance measures for the specialized programs to identify new measures or to enhance existing ones to increase the emphasis on assuring 'capacity' and 'access' to these specialized programs.

These actions should help resolve differing perceptions regarding our special programs, and, hopefully, provide new insights into how we can strengthen these programs. VA's special programs help define us as a unique health system for veterans. We are committed to not only maintaining these programs, but to improving them. In doing so, however, it must be understood that changes will likely be made in the operation of these programs. Such changes may initially be disconcerting or challenging for the affected constituencies.



Thomas L. Gathwaite, MD  
Deputy Under Secretary for Health

**Post-Hearing Questions  
Concerning the July 23, 1998 Hearing**

**for  
Dr. Thomas L. Garthwaite  
Deputy Under Secretary for Health  
Department of Veterans Affairs**

**from  
The Honorable Lane Evans  
Ranking Democratic Member  
Committee on Veterans' Affairs  
U.S. House of Representatives**

1. Your testimony seems to suggest that specialized services are delivering about as much care as they always have. Why do you think that veterans and your own Advisory Committees seem to have such a different perception of what is happening in the specialized care programs?

**Response:** Advisory Committees and Veterans Service Organizations appropriately focus on events associated with changes which might impact specific populations of veterans, while Headquarters is looking at the balance of care for all veterans including those unable to access care due to inefficient use of resources. Bed closures, for instance, at a facility that has relied, perhaps too much, on hospital-based treatments, might provoke vocal concerns by staff and veterans alike that medical care is being cut. In fact, new intensive outpatient programs are often able to provide even better care with provision for a place to stay while undergoing clinic treatment. This can be provided through hoptels, residential rehabilitation units, domiciliaries, or other arrangements in the community, at far more reasonable cost. The improved access to care through our many new community based outpatient clinics may not be readily apparent to those near existing hospital centers. Change, and even anticipation of change, is threatening to nearly all of us and can lead to understandable concerns. Furthermore, there is considerable variation among VISNs. For instance, veterans and clinicians from the Northeast and upper Midwest, where funds are being shifted at a VISN level to the more numerous veterans in the South and Southwest, might well have concerns about the impact of those budgetary cuts. It is not easy to hear that your network is inefficient when you believe you are working hard. During this challenging transition period, we will continue to track trends for the specialized care programs and take action, if necessary, to ensure high-quality care.

2. What steps have VA Headquarters taken to ensure VA special emphasis programs are a high nation-wide priority?

**Response:** In the FY 1998-2003 period, VA Headquarters plans improving the care for special veteran populations in a number of areas. For example, we plan to:

- Implement the VA-wide use of the Addiction Severity Index (ASI) to monitor individual veteran addiction treatment.
- Lead the development of new Blind Rehabilitation Program Standards in conjunction with the National Advisory Committee established by the Rehabilitation Accreditation Commission Board of Trustees.
- Fund three new Geriatric Research, Education and Clinical Centers. In addition, VA will continue to participate in the Chronic Care Network for Alzheimer's Disease national demonstration project on managed care for dementia patients and their families.
- Increase the percentage of participation in the Community Homelessness Assessment Local Education and Networking Groups to 100 percent by 2003 from 92 percent participation reported in FY 1997.

- Implement the use of Global Assessment of Function (GAF) measurement system for monitoring the treatment provided to veterans diagnosed with Post Traumatic Stress Disorder (PTSD).
- Improve the care of amputees and reduce the incidence of amputations among diabetic patients by increasing referrals to foot care specialists.
- Continue the monitoring of prosthetics orders in order to minimize delays in service.
- Implement a system of problem severity rating measurement and work toward reducing the level of severity found in FY 1998, the base year.
- Evaluate every mental health patient and determine the prevalence of seriously mentally ill among veterans treated in VA facilities. Use the GAF measurement system to monitor the effectiveness of their care.
- Monitor the level of consumer satisfaction among (outpatient and inpatient) Spinal Cord Disabled veterans receiving care in VA facilities.
- Operate Traumatic Brain Injury Lead Centers at full capacity and increase the rate of discharge to the community (69 percent of all discharges in FY 2003).
- Fund 6 MIRECCs.

These are a selection of VA Headquarters initiatives for ensuring high nationwide priority for special emphasis programs in the VA medical care system.

3. Some of the specialized programs, such as spinal cord injury and blind rehabilitation, are national programs, and do not correspond with the network management hierarchy. How has VA addressed this problem to ensure that veterans from other networks using these national programs do not fall through the cracks? Where is VA in developing its inter-network transfer pricing methodology?

**Response:** The Veterans Health Administration (VHA) is committed to improving access to and coordination of care for all our patient population. The framework underlying the network of care for the Spinal Cord Injury (SCI) patient population extends from the 23 SCI Centers to the approximately 29 SCI support clinics and 120 SCI primary care teams at non-SCI Center facilities. Designated SCI catchment areas, in place prior to the VISN reorganization, are still honored. This catchment system recognizes the long-standing, patient-provider relationship and attempts to minimize the travel burden for the patient by considering the distance between a veteran's local VA facility and the closest SCI Center.

The continuum of care for this patient population is centered on the specialized expertise of interdisciplinary care teams within the SCI Centers. The SCI support clinics consist of at least a physician, nurse and social worker and are targeted for locations where sufficient outpatient workload exists at a distance from the SCI Center. Approximately 65 facilities and 80 teams have attended the national SCI Outpatient Support Clinic training since 1992. The expected outcome for the training is that these teams will assist the SCI Centers in tracking the patient population, manage referrals to the SCI Centers, provide consultation on inpatients and manage outpatients with SCI, as able. Similar personnel are identified at each non-SCI VA facility and serve as SCI primary care teams, many of whom have attended the national training and/or had training from their lead SCI Center. The social worker for the support clinic or primary care team typically communicates referrals to the SCI Center and handles input of Spinal Cord Dysfunction (SCD) Registry data. The overall goal is to provide increased access to knowledgeable local care and appropriate referral to SCI Centers as clinical needs dictate.

Visual Impairment Services Team (VIST) Coordinators are located at over 90 VA medical centers and outpatient clinics nationwide to assist in the coordinated care of our blinded veterans. These coordinators have been specifically organized to provide coordinated outpatient services to blinded veterans. The team is comprised of representatives from each discipline in the medical center who can offer a service to blinded veterans. The VIST coordinator ensures that

all eligible blinded veterans are informed of VIST services and invites them to the health care facility annually for a review of the physiological, psychological, social and prosthetic needs, plus a comprehensive review of benefits. VIST Coordinators serve to strengthen the comprehensiveness of blind rehabilitation services and provide early rehabilitative intervention for veterans in their adjustment to the impact of sight loss. Additionally, VIST Coordinators are the primary referral source to the inpatient Blind Rehabilitation Center programs.

The nine inpatient residential Blind Rehabilitation Centers across the country (which includes one in San Juan, PR) provide a comprehensive inpatient rehabilitation program designed to assist blinded veterans in overcoming the debilitating effects associated with daily independent functioning and to develop positive attitudes and self concepts concerning blindness. The Centers accept blinded veterans from multi-state catchment areas that also cross VISN lines.

In FY 1995, 14 new positions were established as Blind Rehabilitation Outpatient Specialists (BROS) whose primary function is to assist in reducing the waiting time for veterans to be treated at the Center programs. Trained blind rehabilitation specialists work with veterans in their local environment for pre/post Center training and will train veterans who may not be able to participate in the inpatient program. This new outreach program will serve more blinded veterans and provide low-cost, high-quality care.

The Veterans Health Administration's Veterans Equitable Resource Allocation (VERA) system provides financial incentives for provision of care across networks through the use of the Pro-Rated Person (PRP) workload counts. The PRP is a measure of workload based on the proportionate distribution of costs across networks; this ensures that each network receives funds in proportion to the contribution they make to the care of veterans who are seen in more than one network.

VHA has decided to implement a transfer pricing system. Tenets include the following:

- Establishment of a Medicare-based, default-pricing schedule with the option for networks to negotiate pricing arrangements with other networks to encourage and support ongoing referral patterns.
- Modification of VHA's existing Integrated Billing Package to accommodate transfer pricing.
- Testing the system in FY 1999 with full implementation beginning in FY 2000.
- Development of a preauthorization process for care services not provided by the home network, unless the care is determined urgent, emergent or otherwise requires a special exception. VHA will ensure that preauthorization does not become a barrier to getting care, nor become too bureaucratic.

VHA's goal is that transfer pricing will be transparent to the veteran.

A Transfer Pricing Implementation work group has been chartered to provide planning guidance and to work out the details of implementation during the coming year.

4. What type of authority do the service chiefs for mental health and behavior, spinal cord injury and blind rehabilitation have over programs? What is the incentive for managers to listen to their guidance?

**Response:** These service directors are program managers, not line managers. Line management in VHA flows from the Office of the Under Secretary for Health to the networks and the facilities. Program managers "direct" their programs in the sense that they develop national policy and guidance for their programs, serve as sources of expertise for Headquarters and the field and represent VHA at the national level with professional organizations, veterans service

organizations, academia, other Government agencies, the Congress and the larger medical community.

Field management has strong motivation to regard the guidance and advice of national program managers. They have expert knowledge of their specialty areas, have a broad corporate perspective not present at the field level and are able to serve as brokers for the transfer of lessons learned and best practices across VHA. They are in regular contact with their field counterparts through conference calls, mail groups, advisory groups and education sessions. Indeed, for these reasons, field managers regularly seek their opinions on a variety of program issues and include the guidance received in their decision making.

I want to note, in particular, that Headquarter's program officials have continuous and open access to the line chain of command in VHA. When they are aware of a situation in the field that appears to be out of line with national policies and directives, and they have been unable to resolve the issue through their own efforts, they are expected to refer the matter to the Office of the Under Secretary, where it can be addressed. I consider this an important part of their management responsibilities, and, in fact, such interactions are expected and encouraged.

5. How do you explain the variance in numbers that PVA and the VA Federal Advisory Committee on Prosthetics and Special Disabilities have for prosthetic services and those reported to Congress?

**Response:** Paralyzed Veterans of America (PVA) makes frequent visits to the VA facilities. As a result, their monitoring system detects day-to-day fluctuations in staffing and beds. VA relies on annual data from national databases for the data contained in the report. As a result, some variance in the numbers reported is inevitable. This may explain much of the difference in operating bed levels. PVA also indicates that there are differences in the staffing levels reported by their representatives versus what VA reports. Their reported staffing levels include only physicians and nurses, whereas the VA report includes all employees assigned to the SCI unit.

The VA Federal Advisory Committee on Prosthetics and Special Disabilities cited apparent problems in patient counts and dollars. In particular, they cited the increase in costs in the Blind Rehabilitation program at VAMC Seattle. This discrepancy is attributable to the consolidation of VAMCs Seattle and American Lake into a single integrated unit in FY 1997. The data volatility is merely an artifact of the way the reporting system handled the consolidation, i.e., by assigning all combined costs and workload to Seattle. The Advisory Committee also indicated that beds and FTEE were not adequately defined. However, their comments were based on an early draft of the report. The final version of the report does include definitions of these terms.

VA agrees with the Advisory Committee on the seriousness of delays in delivering prosthetics orders and on increasing waiting times for appointments. We are concerned that an increase in workload has resulted in a gradual increase in delayed orders. We have taken specific actions to address this issue including staff adjustments, central earmarking of funding and continued careful monitoring of delays. We also plan to contract for a management study of our Prosthetic and Sensory Aids Service, including the associated data questions, to assure that the issues raised during the hearing are resolved.

6. PVA states that not all VA facilities accommodate federal accessibility standards – this was pointed out at one facility and they scrapped the project. What are you doing to ensure VA complies with federal code to enact disability standards in construction projects?

**Response:** The Veterans Health Administration's Office of Facilities Management (FM) ensures that buildings constructed, altered or leased by the Department of Veterans

Affairs Headquarters are accessible and usable by physically disabled persons in conformity with established Federal and Departmental policies and standards. FM's project managers direct VA's consultant architect-engineers (A/Es) to follow the Uniform Federal Accessibility Standards (UFAS) and VA's other standards concerning accessibility. Although FM's project managers are responsible only for major leases and non-delegated major construction and renovation projects over \$4 million, FM also provides service to all VA's facilities nationwide. FM's services include:

- Publish and maintain VA's Barrier Free Design Guide (PG-08-13) to VISNs, VAMCs, VA's A/E consultants, and the public. This VA supplement to the UFAS indicates the special barrier free requirements needed for health care facilities. This guide also is provided on the internet and is one of the most requested VA construction documents.
- Support the Assistant Secretary of Human Resources and Administration on all national accessibility issues discussed at Architectural and Transportation Barriers Compliance Board (ATBCB) functions and represent the Department as liaison in his stead.
- Review accessibility complaints filed by the public against VA with the ATBCB.
- Serve on inter-governmental committees working to reconcile and combine UFAS, which are legally required for Federal Facilities, and the Americans with Disabilities Act Accessibility Guidelines (ADAAG), which are legally required for non-Federal facilities. Eliminating conflicting standards will result in faster design, eliminate construction delays and lower construction costs.
- Answer requests for information (RFI) from field facilities. Each year FM responds to over 80 field RFIs related to Accessibility.

7. Congress is witnessing the massive elimination of inpatient mental health beds without adequate outpatient and community resources to meet veterans' health care needs. How can you assure us that VA is providing adequate care for the seriously mentally ill?

**Response:** VHA has two approaches to assure adequate care. The first approach is to develop outcome measures for treatment of SMI veterans that are independent of the physical location of the veteran. The development this year of a functional measure, the Global Assessment of Functioning (GAF), will give us one measure of the results of care that will be used at the network planning level. A second approach, by our Seriously Mentally Ill Treatment, Research and Evaluation Center (SMITREC) at Ann Arbor, is to follow individual cohorts of all SMI veterans discharged since 1988 throughout the system to see if, indeed, those veterans are followed up appropriately.

With respect to veterans with substance use disorders, where the figures do suggest a national three per cent decrease in total numbers of veterans treated (Capacity Report to Congress, page A-40), the closure of substance abuse inpatient beds has engendered both positive accomplishments and some problems. Among the positive accomplishments have been the massive reduction in the inappropriate utilization of acute inpatient resources for patients with substance use disorders and the increased utilization of ambulatory resources. On the other hand, the development of alternative residential treatment resources, while expanding, has yet to fill the need for these settings in a number of VISNs. Similarly, while specialized ambulatory care has expanded in many VISNs, additional efforts will be expended to assure that adequate resources are available to treat veterans in need. In addition, the development, over the last two years, of the Addiction Severity Index data base has enhanced the ability of our planners at the VISN level to monitor care for this group of SMI patients.

8. Your statement says that VA is reducing capacity because demand from veterans is decreasing in certain programs. PVA said in testimony that this is not the case for spinal cord injury and that demand has been driven by supply

(inadequate staff and beds). Were there other programs to which you were referring? What proof is available to support this claim?

**Response:** The primary program for which demand is declining is amputation. Greater emphasis on the preservation of limbs and better management of veterans at risk, particularly those with diabetes, result in fewer amputations per year. With the implementation of the Preservation Amputation Care and Treatment (PACT) program, all patients with diabetes are assessed and educated on proper foot care. Also, foot wounds and ulcers that can lead to amputations are treated. Our assessment is that the decline in the number of individuals treated reflects enhanced treatment outcomes via fewer amputations.

**Post-Hearing Questions  
Concerning the July 23, 1998, Hearing**

**for  
Dr. Denis J. Fitzgerald  
Network Director, VISN 1  
Department of Veterans Affairs**

**from  
The Honorable Lane Evans  
Ranking Democratic Member  
Committee on Veterans' Affairs  
U.S. House of Representatives**

1. There did not appear to be major problems with the delivery of spinal cord injury care in VISN 1. What was the impetus for moving to a product line management approach there?

**Response:** All clinical programs in VISN 1 were evaluated to determine the benefits to be derived from the implementation of service lines. We have discussed the Spinal Cord Injury (SCI) program with the leadership of the local Paralyzed Veterans of America (PVA) periodically during the past 18 months. These discussions focused on the programmatic goals and objectives as expressed by local PVA leadership and reflected in the current national PVA Strategic Plan for VISN 1. VISN leadership considers the service line management structure to be a very appropriate vehicle to raise the SCI program to the next level and to achieve the desired goals and objectives.

We are in the process of scheduling meetings with local and national PVA representatives to address further questions and issues. These meetings will serve as a forum to exchange ideas, information and opinions about how the service line concept will improve the delivery of care to spinal cord injured veterans. The decisions reached in these meetings will determine whether or not we proceed with the implementation of a SCI Service Line in VISN 1 at this time.

2. If VISN 1 were sufficiently reimbursed for the care provided in West Haven to blind veterans from other Networks, would you still feel the need to reduce the size of the inpatient program there?

**Response:** Appropriate reimbursement for all specialized programs, including Blind Rehabilitation Services, would be a fair and equitable approach. The issue at West Haven is not, however, a financial, or even a space, issue. It is one of demand. I am told that the waiting list for admission to the Blind Rehabilitation Program at West Haven is commensurate with a typical waiting list for a 30-35-bed unit. Apparently the existing 45-bed unit is simply too large for the demand being experienced. We feel the excess beds might be better utilized in another location where there would be sufficient demand to fill the beds. I think our interest in providing needed services to blind veterans is reflected in our recent expansion of the computerized training program at West Haven. We doubled the number of beds allocated to this program from four to eight in response to the demand for such services. We continue to evaluate and address the needs of our blinded veteran population, and at this time, we feel we can best serve those needs by offering the 15 excess beds to another VISN that can effectively utilize this capacity. This potential option continues to be discussed.

3. Do all of the seriously mentally ill veterans you treat on an inpatient basis have discharge plans? Case managers?

**Response:** Discharge planning for all seriously mentally ill veterans begins upon admission to an inpatient program. It continues throughout the veteran's inpatient stay and culminates in a carefully developed discharge plan that

assures appropriate placement and follow up for all seriously mentally ill patients upon discharge from inpatient care. All patients are discharged to a specific setting and are scheduled for follow-up appointments as outpatients soon after discharge.

Case managers are assigned to those patients who have been clinically determined to be at high risk for potential problems. This includes veterans with complicated diagnoses who may require intensive follow-up care. Also, those who need extensive assistance to coordinate their living arrangements, to ensure compliance with follow up treatment and to monitor their progress are assigned a case manager. Other patients who are determined to be clinically stable and not in need of the level of monitoring associated with a Case Manager are followed up with regularly scheduled outpatient visits.

**Post-Hearing Questions  
Concerning the July 23, 1998, Hearing**

for  
**Dr. Leroy P. Gross**  
Director, VA Mid-Atlantic Network, VISN 6  
Department of Veterans Affairs

from  
**The Honorable Lane Evans**  
Ranking Democratic Member  
Committee on Veterans' Affairs  
U.S. House of Representatives

1. You claim VISN 6 implemented service line management in part to better address the needs of seriously disabled veterans. But some VSOs, like PVA, think product or service lines may actually be hurting specialized programs because they put decisions about clinical care in the hands of administrators who don't necessarily understand these programs well. Will you share with us why you think service lines help?

**Response:** In the deliberation and development process, the founders of the implementation plan for Service Lines in VISN 6 carefully considered the programmatic clinical needs among the veteran population. Based on the assessment, direct-care Service Lines in VISN 6 were defined along major clinical designations, such as Spinal Cord Injury & Disease (SCI&D); Primary Care/Preventive Health; Mental Health; Acute and Tertiary Care; and Geriatrics and Extended Care. Services are coordinated VISN-wide under the leadership of a designated, individual, Service Line Manager, who is in every case, a physician with experience in the clinical care of patients in the diagnostic category represented. Each facility also has a designated, clinical, Service Line Chief who coordinates care locally in concert with the Service Line Manager. Service Lines were adopted to provide more effective coordination, consistency, accessibility and alignment of resources for veterans served. This seamless, virtual healthcare system, under Service Line Management principles, will be most helpful to our primary mission of patient care.

2. VISN 6 performed particularly poorly compared to other VISNs in ensuring continuity of care for seriously mentally ill veterans. What steps are you taking to ensure improvements in this area?

**Response:** Improving continuity is being addressed by the Mental Health Service Line in a variety of ways, usually involving the linkage of several initiatives together to achieve strategic goals. For example, simply reducing bed days of care and shifting resources from inpatient to outpatient services does not necessarily improve patient care. However, combining the above with homeless initiatives, case management activities, activation of the Manic Depressive Disorder Clinical Practice Guideline in primary care settings and, of course, the linkage of services between mental health and primary care will assist us in achieving the desired results. A number of innovations are currently being instituted in VISN 6. Examples are as follows:

**a. Mental Health/Primary Care Outpatient Initiatives:** Salisbury VAMC has successfully shifted a portion of inpatient resources to outpatient needs through closure of one ward. Part of the staff were relocated to the recently activated Winston-Salem Outpatient Clinic (OPC) and the soon-to-be-activated Community Based Outpatient Clinic (CBOC) at Charlotte. In both, Mental Health will be co-located with Primary Care to enhance patient care delivery. This should help address the access issues and 30-day follow-up challenges. Proposals are planned to link Mental Health Satellite Clinics at Salem with future CBOC

activations, particularly in Danville, VA, and the recently approved Jacksonville, NC, CBOC.

**b. Case Management:** Durham, Hampton, Richmond and Salem received seed money in the past year to begin case management activities. All four facilities identified highly recidivistic inpatients to target for the first use of case management activities. In addition to tracking readmission rates, these teams are similarly using outcome measures, such as the Behavioral Psychiatric Rating Scale and the planned use of a Quality of Life scale, to assess their effectiveness. Richmond has proposed a further enhancement to case management through the use of scheduled readmissions as part of a psychiatric respite-type program. This program has demonstrated reductions in treatment costs with demonstrated improvements in Quality of Life, clearly serving as a model for direct linkage to case management. This provides an important "safety valve" to the seriously, chronically mentally ill at any given facility. It has been shown that timely scheduled intervention, such as this, can often preclude the need for further, longer-term hospitalization. Additionally, these patients also are more acceptable to adult-care homes which facilitates their outplacement from inpatient Psychiatry. When used within observation bed-status, additions to acute bed days of care are similarly avoided.

An alternative approach taken at Salisbury VAMC has been the development of a closer cross linkage between the Residential Care Program and the preexisting Intensive Psychiatric Community Care Program (IPCC). The staff of these two programs previously had a great degree of geographic overlap resulting in clinical downtime due to required travel within these programs. They were able to creatively merge their activities to preclude this and shift their resources to other previously underserved areas. This was done without an FTEE increase. Part of the approach also required a reassessment of patients currently enrolled in the IPCC to ensure they are assigned to an appropriate level of care.

**c. Continuity of Care:** The Mental Health Service Line in Network 6 has had particular difficulties with 30-day follow-up and readmission rates according to the FY 1996 and FY 1997 Northeast Program Education Center report. Several innovative approaches implemented to address this include the use of virtual teams such as those at the Richmond VAMC. As part of the service line integration, this facility took the lead in a closer merger between various disciplines into integrated teams with improved communication between inpatient and outpatient services. Salem VAMC has alternately taken a different tack through the use of outpatient clinics one day a week for acute inpatient psychiatrists. The combination of these two approaches has been recommended to all sites for prompt evaluation and implementation. Although demanding for inpatient psychiatrists, it does enhance both continuity and coordination of care while providing a limited enhancement of outpatient capacity without an FTEE increase. All facilities with an acute inpatient psychiatry setting are exploring the development and implementation of scheduling acute inpatient practitioners for limited outpatient follow-up clinics and aggressively merging previously disparate disciplines into smoothly functioning "virtual teams."

**d. Vet Center Coordination:** Many possibilities exist and are being explored which should help with the 30-day follow-up. VISN 6 is clearly identifying geographic areas where further service enhancements may be necessary. As an example, the Durham VAMC is currently coordinating with the Greenville Vet Center to establish a telepsychiatry program.

**e. Homelessness Initiatives:** The Mental Health Service Line has received approval to establish contracts for Oxford House programs in Richmond, Durham and Charlotte. At present, the Network is similarly exploring linkages with Dr. Robert Rosenheck at the Northeast Program Evaluation Center as part of a new homelessness study funded by Headquarters.

**f. Clinical Record Enhancements:** Efforts are underway to develop standardized progress note templates, as well as VISN-wide treatment plans, to serve as necessary "Seamless/Timeless Treatment Plans." Successful implementation is dependent upon full use and activation of the Text Integrated Utility in the Decentralized Hospital Computer Program (DHCP). The expectation is that one treatment plan would follow a patient regardless of locus of care within the Network. This would allow for easy identification and discussion on the best care approaches, as well as provide a mechanism to improve continuity and easily update treatment revisions, as the patient's clinical needs and conditions change.

3. VISN 6 performed particularly poorly compared to other VISNs in ensuring continuity of care for veterans treated for Post Traumatic Stress Disorder. What steps are you taking to ensure improvement in this area?

**Response:** Although VISN 6 was an outlier in several of the continuity measures for patients with Post Traumatic Stress Disorder (PTSD), the overall performance score was not a negative outlier. Nonetheless, efforts are underway to link each veteran's treatment into a continuous model through close collaboration with staff from Readjustment Counseling Services. PTSD programs within VISN 6 consist of two specialized inpatient PTSD units located at Salisbury and Salem VAMCs. In addition four PTSD clinical teams (PCTs) are in operation at Asheville, Durham, Hampton and Salisbury VAMCs. During FY 1997, the Primary Clinical Teams treated 583 new PTSD patients. Also during FY 1997, a total of 2,133 veterans was treated with an average length of stay of 39 days. The proportion of PTSD veterans receiving psychiatric outpatient care within 30 days of discharge increased slightly by 0.3 percent in FY 1997, and many of the actions cited above should demonstrate continuous improvement. In addition, the Salem VAMC has enhanced its long-standing satellite clinics with substance abuse staff for aftercare and PTSD staff for screening and follow-up care. Both of these initiatives have met with great success through case identification as well as patient satisfaction and enhanced compliance with aftercare.

4. VA's report says there were 100 Spinal Cord Injury beds at Richmond in FY 1997, but PVA counted 80 staffed available beds this April. You claimed that your numbers differed from the capacity report and PVA's estimate. Where do your numbers differ from the capacity report? Please identify the programs in which there are discrepancies.

**Response:** VAMC Richmond has 120 authorized acute spinal cord injury beds. In FY 1992, operating beds were reduced to 110 due to the national decline in new spinal cord injury cases and a decreased demand for acute spinal cord injury beds. In FY 1996, operating beds were again reduced to 100 as new injuries continued to decline and average daily census dropped from 95 patients per day to 79 patients per day. The occupancy rate of the VAMC Richmond acute spinal cord injury program, as of July 1998, is 66 percent with no waiting list. The Spinal Cord Injury program at VAMC Richmond has replaced the declining acute care demand with the development of an interdisciplinary Primary Care Group Practice and a 20-bed Self Care Unit, which meets the current needs of its population consisting of primarily old spinal cord injuries. These veterans require acute care and maintenance follow-up but do not need the long-term institutional care provided at the VAMC Hampton. By altering programs to meet the changing health care needs of its patients, VAMC Richmond successfully meets the ongoing acute care needs of its spinal cord injury population. Care is rendered in the most appropriate environment congruent with this complex patient population's bio-psycho-social needs. Patients treated, in fact, have increased since 1992. The number of outpatients treated has increased 15 percent since FY 1992, due to shorter lengths of stay, while the number of unique spinal cord injury outpatients treated has increased 37 percent since FY 1992.

The VAMC Hampton long-term SCI unit has 64 operating staff beds with an occupancy rate of 81 percent and no waiting list as of August 1, 1998. The patients are long term and discharges are few.

5. PVA reports that you are 12 nurses short at Hampton's Spinal Cord Injury center and 17.5 nurses and 3 physicians short at Richmond's SCI center. Are you aware of these staffing shortfalls? Do you agree? If so, what steps are you taking to correct them?

**Response:** Eighty acute care beds at Richmond VAMC are currently staffed with 6 physicians, including a full-time chief, 22 registered nurses (RN) for both units, 18 licensed practical nurses (LPN), 4 nursing assistants (NA), or Health Techs, and 3 physician assistants (PA). They are currently recruiting for one RN. The self care unit is staffed with one RN case manager and one administrative clerk. Patients provided care in the Self Care Unit, who experience alterations in health, are readmitted to the acute-care unit.

VAMC Hampton's long-term care, Spinal Cord Injury and Disease (SCI&D) Center is staffed with three physicians with the Service Line Chief devoting 50 percent of his time to the Neurology Clinic. There are 13.5 RNs, 14.4 LPNs, 17.0 NAs or Health Techs assigned. They are currently recruiting for 11 additional nursing staff (i.e. 5 RNs, 4 LPNs and 2.0 NAs).

It is noteworthy that support of the SCI&D patient is a multi-disciplinary effort. Thus, physician/nurse staffing is not a true reflection of the staff providing health care services to our SCI&D population. For example, total direct-support FTEE for Hampton, by Cost Distribution Report data as of June 30, 1998, is 79.57, and for Richmond, total direct-support FTEE, as of the same period, is 150.25. In these FTEE figures are psychologists, social workers, recreation therapists, respiratory therapists, nutritionists, pharmacists, chaplains, rehab medicine specialists, etc. Current vacancies for the assigned ceilings are not reflected in the numbers. These numbers differ from the PVA report due to a difference in the way the databases define FTEE for reporting.

6. Your testimony states that "to the best of your knowledge" there are no access problems for Spinal Cord Injury services in VISN 6. What steps might you take to ensure this contention:

**Response:** This statement was based on the data available to me that indicates strongly that there is no waiting list in VISN 6 for veterans in need of care in the specialty of Spinal Cord Injury & Disease. As a specialized program, SCI&D has been routinely and regularly monitored for both quality and access. Under the Service Line Management concept, attention to the program has been increased, as there are a Service Line Director and Service Line Manager who now assist in the assessment of this program.

Congressman Evans to Stephen P. Backhus, Director, Veterans' Affairs  
and Military Health Care Issues, U.S. General Accounting Office

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**RESPONSES FOR THE RECORD TO  
FOLLOW-UP QUESTIONS FROM JULY 23, 1998 HEARING  
ON VA SPECIAL DISABILITY PROGRAMS**

**1. Based on your work to date, would you say that VA is giving adequate attention to its own two Advisory Committees in terms of measuring the capacity and effectiveness of specialized programs?**

VA is required by Public Law 104-262 to implement the legislation in consultation with the Advisory Committee on Prosthetics and Special Disabilities Programs and the Committee on Care of Severely Chronically Mentally Ill Veterans. VA solicited input from both of these Committees when developing its draft report to the House and Senate VA Committees, and both committees provided written comments on the 1997 and 1998 reports. VA considered and addressed all of the recommendations made by the Committees, although all of the recommendations were not implemented. For instance, the 1998 report noted that VA would delay its goal of replacing capacity measures with outcome measures because it agreed with the Advisory Committee on Prosthetics and Special Disabilities Programs that 2 to 3 years would be needed to fully develop and collect the data needed to put the outcome measures in place. The 1998 report also noted that VA limited the category of mental illness to serious mental illness in accordance with the recommendation of the Committee on the Care of Severely Chronically Mentally Ill Veterans and adopted the committee's definition of serious mental illness. However, VA did not implement other recommendations, such as using geographic and market penetration measures of access.

**2. Did you agree with Dr. McCormick's testimony that if VA were adequately addressing some of the specialty programs, such as substance abuse, on an outpatient basis, we would not see the precipitous decline in expenditures VA has exhibited in its capacity report?**

Dr. McCormick's testimony notes that the 3 percent decline in expenditures for the care of seriously mentally ill veterans and the 20 percent decline in expenditures for seriously mentally ill substance abusers results from decreases in inpatient care. We agree that VA could serve more veterans based on estimates of unmet demand because outpatient care is less expensive than inpatient care and would expect to see increases in the numbers of veterans served using current expenditures. We also agree that the shift to outpatient care discussed by Dr. McCormick raises concerns about measuring capacity that are not easily addressed solely on the basis of information presented in VA's reports to the Congress. VA currently defines capacity as the number of unique individuals served within specialized bed sections and clinics and the dollars expended for their care. However, consensus has not been reached among all stakeholders as to how maintenance of capacity should be measured in VA's changing healthcare delivery system. For example, other measures will be necessary as more veterans are served in the community and fewer are served as inpatients. During our review, we plan to explore whether VA has developed an adequate array of services to successfully reintegrate seriously mentally ill patients into the community.

**3. Do you think providing a performance measure in the VISN directors' performance contract to address each of the protected specialized services would give Congress better assurance that these programs would receive adequate attention?**

Performance measures are a generally accepted way to achieve specific program goals. If properly executed, this would be a reasonable way to give VISN directors and others responsible for allocating and managing resources clear incentive to better serve veterans with special disabilities. Establishing explicit accountability for delivering specialized services would help ensure that VISN directors pay close attention to access and quality as well as efficiency.

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**4. To what extent do you believe the vacancies in clinical staff that have been identified in your report, by the Advisory Committees and others, [are] damaging veterans' quality of care and access to services? Has VA identified this as a problem to you? To what do they attribute staff vacancies?**

We have not assessed the impact of vacancies in VA clinical staff on the quality of care and access to services, but VA attributes staff vacancies to (1) reductions-in-force, (2) facility reorganizations and integrations, and (3) changes in service delivery approaches which have modified the types of health care professionals needed by VA.

With regard to the blind rehabilitation program, VA reported in its 1998 report to the House and Senate Veterans Affairs Committees that waiting times to get into the program had increased between 1996 and 1997, in part because of delays in filling vacant instructor positions. In addition, program officials in central office raised concerns over the accuracy of the reported number of staff years dedicated to the blind rehabilitation program. They noted, for example, that the report to the VA congressional committees showed 436 staff years, but VA program officials believe that there are only 365 staff years committed to the program and indicated concern about some support staff being included in these counts. Specifically, they questioned the counting of dietitians as full time positions in the blind rehabilitation program. This reinforces our general concerns about the reliability of data being used to measure the extent of services being provided in specialized programs.

**5. You seem suspicious of an across-the-board cut VA made in expenditures for amputee care for FY 96 as they "refined" their data. Please explain.**

Both the 1997 and 1998 reports to the House and Senate Committees on Veterans Affairs contained information on the number of veterans participating in special disability programs and the related costs for 1996—the base year against which compliance with the legislation is determined. According to VA officials, the 1996 baseline "differed slightly" in the 1997 and 1998 reports because the 1997 report inadvertently included in the amputations workload the amputations of toes other than the great toe, which is considered more likely to lead to a disabling condition than other toe amputations. Our review, however, shows significant differences in the 1996 baseline numbers for amputations. Specifically, the 1997 report showed that VA performed 4,813 amputations at a cost of \$11.8 million in 1996, while the 1998 report showed that VA performed 4,765 amputations at a cost of \$5.9 million in the base year. In other words, in the 1998 report, VA reduced the number of amputations by one percent but at the same time reduced the costs by 50 percent. In addition, of the 151 medical centers reporting amputations, 143 reported a 50 percent decline in expenditures, and the other 8 reported cost reductions ranging from 45 to 59 percent. We would not have expected the expenditure declines to be virtually identical across these medical centers. Moreover, had the baseline not been reduced, VA's 1998 report to the House and Senate VA committees would have shown that expenditures for amputations declined by about 50 percent from 1996 to 1997 rather than the 2 percent reduction reported.

**6. Are the patient satisfaction surveys VA developed for Spinal Cord Injury and Blind Rehabilitation the same or different than those for other types of VA patients? Should they be the same or different?**

The Spinal Cord Injury (SCI) and Blind Rehabilitation Service patient satisfaction surveys are different than those for other types of VA patients for good reasons. Both of these programs involve services more extensive than those generally provided to other veterans, and it is important to use tailored questions to understand the unique situations of these veterans. To obtain information on the satisfaction of veterans with Spinal Cord Injury, VA is using its general outpatient satisfaction survey with several additional questions designed specifically for veterans with SCI. VA's Blind Rehabilitation Service conducts customer

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satisfaction surveys that are unique to veterans in the Blind Rehabilitation program. The survey is national in scope and administered by the Rehabilitation Research and Development Center at the VA medical center in Decatur, Georgia. It is a patient's self report on the services they received as inpatients in the blind rehabilitation program.

Congressman Evans to Dr. Richard McCormick

Questions for Dr. Richard McCormick, Co-Chairman, Committee on Care of Severely Chronically Mentally Ill Veterans

1. VA is in the process of implementing product lines at the facility and at the network levels. First, do you believe this is the best way to manage VA resources? What are some of the steps VA can take to ensure successful implementation of these mental health product lines?

It is imperative, as the need for mental health services among veterans continues to increase, and resources for providing such services are held constant, that we maximize the healthcare value we derive from our current resources. This must include closely evaluating the clinical outcomes and costs associated with our current mental health programs and delivery systems. It must also include modifying care delivery systems in light of new scientific advances and changing community benchmarks for care. Mental health service lines (at times also called "care lines" or "product lines") offer one viable option for meeting these challenges. Mental health services have for many years employed an interdisciplinary approach to treatment. Members of various mental health disciplines, including psychiatry, psychology, social work, nursing, and rehabilitation specialists, as well as clerical and administrative support staff, work together to provide a comprehensive array of treatment and rehabilitation services. Current outside accreditation standards mandate such an interdisciplinary approach. Clinical treatment trials show the advantage of such an approach for various mental health populations. Historically in VHA, providers from various mental health disciplines have worked together on program teams, but the designated leader of the team has not exercised line or budgetary authority over the staff on the team that he or she heads. The various team members have been under the line authority of Service Chiefs responsible for all staff and resources associated with their professional discipline. Service lines shift the line and budgetary authority for all staff and associated resources aligned in a particular mental health program to the managers who are responsible for that program. This allows the managers of the service line to more easily make programmatic changes, including changes in staffing mix, in response to changes in the demand for services, access and patient satisfaction. It also increases the accountability of all staff in the program to the management of the program. This can increase the agreement between overall program goals and the priorities of specific staff members. If properly implemented and managed, service lines can assure greater health care value in these times of great change. A concrete example may be useful. VHA has historically spent a very large proportion of its resources for inpatient care. In the most recent 12 month period 67 % of all mental health expenditures in VHA were still expended for inpatient services. This balance between inpatient and outpatient care is shifting, both within VHA and in the non-VHA community. VHA is actually changing at a slower rate than even most state mental health systems. If this transition is to be successful, the managers responsible for this transition in VHA need to be able to convert some of the current resources being spent on inpatient care to a full array of community based services. This involves major changes in the mix of staff (e.g. reductions in nursing staffing responsible for the 24 hour management of the inpatient unit, and significant increases in community focused, expanded role nurses and social workers). It may also require hiring staff who are willing to work in a broader geographic area. The managers of the mental health programs need to have the authority to make such changes in an orderly and progressive manner. Service lines are a means to provide such authority. Under a local service line structure the service line management ideally has:

- A well conceived strategic plan for providing mental health services to a defined population of veterans
- Line authority over all direct care and key administrative support staff necessary to provide mental health services
- Flexibility to shift resources as necessary to improve the quality of programming, access, efficiency, and patient satisfaction
- A predictable, adequate dollar budget within which the programs can be efficiently managed
- A management information system which allows for the tracking of clinical outcomes, expenditures, patient satisfaction and efficiency.

As an alternative to service lines some facilities employ strengthened management matrices, where the leaders of programs are given some degree of authority over the resources in their programs. Staff remain aligned under traditional professional and administrative services. This approach requires maximal cooperation among the discipline heads, and a shared strategic vision.

Whether a service line structure or a strengthened matrix is used, it is imperative that mental health managers be chosen based on their management skill, clinical expertise and strategic

Questions for Dr. Richard McCormick, Co-Chairman, Committee on Care of Severely Chronically Mentally Ill Veterans

vision, not merely based on their disciplinary specialty. It is then critical that they be empowered to truly manage the resources devoted to the provision of mental health services.

At the Network level, mental health service lines are a viable means to assure overall strategic planning and deployment of resources. This includes assuring that the mental health needs of all veterans in the Network are attended to, rather than just those veterans who reside near to a current VHA facility. Network service lines can also facilitate the development of a full continuum of care throughout the Network. Health care value may be increased by providing some specialized services at only selected locations. Ideally the Network Mental Health Service Line Manager and the local facility service line managers serve as a coordinated management team for mental health services throughout the network. The Network Service Line Manager, as a member of the executive management team for the Network, also assures that the specialized needs of mental health patients are represented in all major network decisions.

Some networks provide overall direction for mental health programming through a Network Mental Health Council or Committee. This body includes representatives from facilities throughout the network. For this to be a viable option the Council must be empowered to truly influence mental health program issues throughout the network, and must have a strong voice in the overall management of the network.

2. You have identified some significant rates of homelessness for VA inpatients. What should VA do to better ensure appropriate placement for these veterans after discharge?

Homelessness among veterans continues to be a major problem requiring ongoing attention. While significant progress has been made, continued improvement requires the following:

- **A continued commitment to address the problem of homelessness among veterans.** For the past decade, the Congress and VA have assigned a high priority to homeless services for veterans. This commitment was actualized through the funding of specialized services for homeless veterans and the strengthening of community partnerships to address the problem. The core mission of the VA has been defined as including addressing the complex set of factors associated with homelessness. For VHA this has meant establishing a definition of health care which goes beyond the narrower bounds of private health care plans, and including a broad range of rehabilitative efforts which have as their goal restoring the homeless veteran to independent community functioning. The rush to benchmark VHA with other health care plans must not erode this broad commitment. The Committee is encouraged by the Undersecretary for Health's recent affirmation that eradicating homelessness among veterans is a "fifth" critical mission for VHA.
- **The identification and outreach to homeless veterans.** Homeless veterans have historically often not actively sought VA services. They are often unaware of their eligibility for services, or alienated from government institutions. Furthermore, homelessness has not always been adequately assessed among those veterans who do come to VHA for health care services. It is imperative that VHA continue its active outreach efforts to homeless veterans in the community, and that improved screening for homelessness be instituted at all VHA access points. The current outreach efforts have focused on geographic areas where VHA has traditionally had facilities. As VHA expands access into new geographic areas, through efforts such as new Community Based Outpatient Clinics, it is critical that outreach efforts for homeless veterans also be expanded to cover these new areas.
- **Uniform access to a full array of vocational rehabilitation services.** Unemployment and inadequate work skills are a key factor that prevent homeless veterans from successfully re-integrating into independent community functioning. This problem is complicated by the fact that many homeless veterans have mental and physical disorders which may impair their vocational ability. In some locations VHA offers a full array of vocational rehabilitation services, including therapeutic work programs, which are designed to provide basic work skills for seriously mentally ill veterans. These programs are very cost effective, in that they partner with local employers to provide meaningful work which is reimbursed at a fair market rate, while at the same time offering an opportunity to therapeutically work with even significantly impaired veterans in an effort to enhance their future independent employability. Unfortunately, a full range of programming is not available at all major VHA locations, limiting access to such services for many homeless veterans.
- **Uniform access to options for transitional living arrangements.** The homeless veteran most often requires a transitional living situation, where he or she can reside in a therapeutic environment while completing rehabilitation efforts. VHA offers such options in multiple

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ways. VA staffed residential settings such as the Domiciliary Care for Homeless Veterans and Therapeutic Work/Transitional Residence Programs offer a superlative level of residential care. In many cases VHA has partnered with community organizations or veterans service organizations to provide transitional living options. This has included: loaning unused VA space for transitional housing staffed by and sponsored by community agencies or VSO's; a large contract homeless residential treatment program; and grants and per diem payments to community homeless providers who develop transitional services for veterans. Currently funding for homeless residential contract services are distributed outside of the VERA model. There are plans to move these funds into VERA in the future. If this does occur it is imperative that the VERA model be modified to provide complex patient status for patients requiring significant residential services. Currently VERA only recognizes stays that occur in VHA staffed beds for the homeless. When funds for contract nursing home beds were moved to the VERA model, the model was modified to credit these services towards complex status. A similar change must accompany any movement of homeless residential services to VERA.

3. Are you satisfied that the measures that VA has selected for assessing continuity of care are sufficient? Given the selected measures, how well overall would you say VA is doing?

VA currently measures continuity of care primarily by calculating the percentage of patients with an inpatient stay who receive VHA outpatient services after discharge. This is a common measure, used in many health care organizations to assess continuity of care for mental health populations. The data for this measure are easily extracted from administrative data bases. The measure serves as a valuable global benchmark of continuity of care. The measure does, however, have significant limitations. These include:

- Continuity is tracked only for the subset of patients who receive inpatient care (only about 14% of the total number of VHA patients receiving mental health services)
- VHA administrative data bases do not capture care received outside of the VA, even when that care is provided by VA contractual funding. Thus the measures may understate the continuity of care when VA staff appropriately refer the patient to community resources, or to contractual providers of services.
- These measures do not differentiate the intensity of outpatient services provided.

With these limitations in mind, VA as a whole is progressively improving in the continuity of care provided for general psychiatric patients and for substance abuse patients. In the most recent 12 month period, there was a 6.2% improvement in continuity for general psychiatric patients, and a 14.7% improvement for substance abusers. There remains, however, an unacceptable level of variability among the 22 VHA networks. For substance abuse the rates of change varied from +39.8% to -22.6%. For general psychiatric patients they varied from +27.4% to -7.5%.

The current measures need to be expanded to include all VHA patients, and efforts need to be made to better track all services received, or at least those paid for by VA. Patient severity measures need to be added along with measures of the intensity of services received, in order to better track the adequacy of the continuum of services for the more severely impaired patients.

4. Ideally, what types of mental health services should be available in Community Based Outpatient Clinics?

Community Based Outpatient Clinics (CBOC's) are intended to provide primary care services to veterans near where they reside. During the most recent twelve month period, 20.4% of veterans using VHA services used a mental health service. It is therefore appropriate that CBOC's include access to basic mental health outpatient services. Mental health services are available in approximately 40% of CBOC's. These CBOC's generally include a small mental health team, including a psychiatrist on at least two or three days a week, and coverage by a psychiatric social worker, psychiatric clinical nurse specialist or psychologist on three to five days a week. This team should include expertise for treating the seriously mentally ill on an outpatient basis, and be capable of providing basic outpatient services for veterans with substance abuse problems. At least one of the team should have experience with treating post traumatic stress disorder. The actual size of the mental health team should be matched to the size of the clinic, and the number of veterans with mental health disorders for whom the new CBOC would be the most accessible VHA facility.

Questions for Dr. Richard McCormick, Co-Chairman, Committee on Care of Severely Chronically Mentally Ill Veterans

5. Given its limited resources, what is realistic for Congress to expect VA to develop in the community?

This is a difficult question to answer. The Committee, noting that less than 40% of veterans who are service connected for a mental disorder use VHA services, continues to believe that large numbers of highest priority veterans need and would greatly benefit from expanded access to VHA mental health services. The current total funding levels for VHA are not adequate to completely address this unmet demand for services. The Committee, therefore, urges priority consideration for supplemental funding to close this gap.

However, even assuming no appreciable change in VHA funding levels, during the most recent 12 month period approximately \$1.3 billion dollars was expended for VHA inpatient mental health services. This represents a capital pool which can be tapped, to some degree, to fund needed community services for the mentally ill. The amount of funds available for reprogramming from inpatient to outpatient or community care, can be maximized by increasing the efficiency of our mental health programs, and utilizing state of the art treatment approaches, which include community based care. The Committee is most concerned that this reprogramming occur as we downsize our inpatient capacity and shift to outpatient delivery systems. This should, at very least, allow VHA to include mental health services in all new access points, and to provide intensive community care and psychosocial rehabilitation for seriously mentally ill patients who are deinstitutionalized. We should also be able to provide intensive outpatient rehabilitation services, with appropriate residential therapeutic care when needed for the homeless, for at least a somewhat increasing number of patients with post traumatic stress disorder or substance abuse disorders.

6. Are we better off keeping veterans in beds if we can't assure them adequate access to community and outpatient care?

Institutionalized seriously mentally ill patients should only be discharged when they are sufficiently stabilized and a thoroughly adequate plan for their reentry into the community has been completed. With the development of a new generation of antipsychotic medications, and significant refinements in intensive community case management and psychosocial rehabilitation approaches, this is feasible for an increasing number of previously institutionalized patients. While implementing a comprehensive package of community oriented services is not inexpensive, it is less costly than long-term inpatient care. It should be possible to re-deploy resources at sites where significant numbers of seriously mentally ill are institutionalized in order to deinstitutionalize selected patients. This is the accepted standard of care when it is feasible for a given patient. Rehabilitating and placing the patient into the highest level of independent community functioning possible also meets the requirement that all patients be maintained in the least restrictive environment possible. It should not, therefore, be necessary to keep a patient hospitalized merely because we cannot provide adequate community care.

**Responses to questions from Congressman Lane Evans  
on The American Legion Testimony  
July 23, 1998**

*1. Your testimony states that VISN 8 and VISN 18 lack long-term mental health programs. Please tell us how you were able to identify this shortcoming and what impact it has on patient care?*

The American Legion established a VISN Management and VERA Task Force in order to track the changes at VHA. The task force has visited VISNs 1, 3, 4, 5, 8, 18, and 21 in the course of eighteen months. During those visits, VISN Directors in both 8 and 18 reported their lack of long term mental health services. The situation is being handled by referring veterans to nearby networks when they need inpatient treatment for such conditions as PTSD or addictive disorders.

The impact this has on patient care is that it is a barrier for patients who cannot or do not want to travel such distances for care. It also separates patients from their social supports by having them so far from home during hospitalization. It impedes coordinating aftercare planning. In addition, emergency hospitalization for acute psychotic episodes must be done in the private sector; thereby reducing consistency in patient care.

*2. Are you satisfied with the data the SMI Committee provides Congress allows us to assess the effectiveness of VA's programs? How about other measures of capacity and access?*

The American Legion is a member of the SMI Committee's Consumer Council, and has been an active participant in the committee's activities. Based on this first-hand experience, The American Legion is very satisfied with the work of the SMI Committee, and commends them for their efforts. The American Legion will continue to be involved in the SMI committee's activities.

The SMI Committee does make several recommendations to improve VA measures for capacity and access that are consistent with the philosophy of The American Legion. VA is urged to consider those recommendations carefully and develop plans for implementation.

*3. American Legion makes site visits to various VA facilities around the country. What particular problems have you noted in VA's delivery of specialized services?*

In general, The American Legion has several concerns regarding the delivery of care in the specialized programs:

- There is no evidence that the dollars saved by closing inpatient mental health beds have been reinvested into community based programs;
- Since the VA has downsized and shifted staff through cross training, there is no process in place that measures the success of the cross training nor the competency of the staff who have been re-trained;
- The long admission waiting times for the blind rehabilitation programs have not been adequately addressed;
- There is initial concern (no real data) that the restructuring of the addictive disorders and homeless programs, plus the closing of inpatient psychiatric beds has, and will continue to lead to veteran incarceration. The American Legion identified this potential issue during a focus group conducted at the Cleveland VA Medical Center. This is a trend that should be investigated and tracked.

*4. Would you tend to attribute the problems VA is having in "maintaining capacity" to decentralization? Budget? Other factors?*

The American Legion attributes the problems with VA's ability to maintain capacity as being budget driven. The Balanced Budget Agreement does not provide VA with appropriations that will keep up with inflation for the next five years. In spite of the fact, the budget will increase, VA buying power will not. The VA, so far, has not been able to reach its MCCR goal of increased collections by 10 percent. (They are averaging about 3 percent.) According to VA, this is attributable to a technological systems glitch that should be corrected by next calendar year. Once VA billing improves, so should their MCCR collections. The American Legion believes this is the future of VA. The MCCF should supplant VA's annual discretionary appropriations rather than off-set funding. The GI Bill of Health would then enhance the MCCF, and give VA a self-reliant edge.

Other factors that hamper VA's ability to maintain capacity are that VERA is a capitated model based on an adverse select population (especially within the special emphasis programs) and, a fixed resource environment. In the private sector, managed care organizations survive by being able to enroll younger, healthier patients, and generate a profit margin. If VA incorporated healthier covered lives into their pool, then there would be more dollars to reinvest into care for the adverse select (older, sicker) population. This is the goal of the GI Bill of Health.

**ANSWERS TO QUESTIONS FOR DAVID W. GORMAN  
 EXECUTIVE DIRECTOR, WASHINGTON HEADQUARTERS  
 DISABLED AMERICAN VETERANS  
 REGARDING JULY 23, 1998, HEARING  
 BEFORE THE SUBCOMMITTEE ON HEALTH  
 FROM THE HONORABLE LANE EVANS  
 RANKING DEMOCRATIC MEMBER  
 COMMITTEE ON VETERANS' AFFAIRS  
 U.S. HOUSE OF REPRESENTATIVES**

**Question 1:** "What is the basis for your recommendation to add 3 employees to the Strategic Healthcare Group for Prosthetics at Central Office?"

**Answer:** To ensure that prosthetics and sensory aids' services are provided in a uniform and cost effective manner, we feel that there must be a central monitoring system in place. Due to current vacancies, there is no oversight being conducted to provide budget review and technical training and evaluation. As stated in our testimony of July 23, 1998, "In an attempt to fill vacant prosthetic services personnel positions, local VA Medical facilities are transferring other personnel within the facilities who are untrained and unable to fulfill the VA's commitment to these men and women who rely on VA health care for improving their functional abilities."

Because of the staff shortage in the Strategic Healthcare Group at VA Central Office, site visitations are virtually nonexistent. Additionally, the review of the budget and technical workups are being postponed. Considering reports from DAV National Service Officers and Hospital Service Coordinators throughout the country, a central monitoring and training system must be put in place in order to correct deficiencies and improve prosthetic's proficiency. It is our belief, that by filling the current three vacancies in the Strategic Healthcare group, inequities in providing needed services and the current backlog of delayed orders will decrease.

**Question 2:** "Do you share the views expressed by Dr. McCormick and Mr. Miller of the VA's Advisory Committees?"

**Answer:** Yes, as Dr. McCormick's testimony reflects, with the deinstitutionalization of veterans with chronic mental illness, there needs to be a reinvestment of inpatient savings into intensive outpatient services. In our testimony, we called for and described these programs. Additionally, we accept the statements provided regarding the collection of data in order to measure capacity as well as the committee's concern that the data collected is not being effectively managed throughout VHA.

As Mr. Miller's statement indicated, subsequent to the realignment into product lines, prosthetic representatives had direct access to the medical facility director in order to manage the workload, staffing and budget. Since the product lines have been implemented, the prosthetic representatives are faced with a myriad of management layers between them and the facility director. We also fully concur with Mr. Miller's testimony regarding the staffing of trained and qualified prosthetics' representatives throughout the nation, as well as the unacceptable level of delayed orders. We further noted with concern the significant proportion of prosthetic representatives who report being fearful of disciplinary action if delayed orders are reported.

**Question 3:** "Are you aware if VA's National Drug Formulary restricts access to Clozaril?"

**Answer:** Clozaril is on the VA's National Formulary; however, it is controlled by the submission of forms to Dallas, Texas following the failure of at least two other anti-psychotic medications. The data available to the Committee on Care of Severely Chronically Mentally Ill Veterans indicate that there were barriers in some facilities to the use of new medications. Some of the barriers included the need for better education of providers, lack of a programmatic structure to support the additional monitoring required for Clozaril, and in some cases, budget restrictions that limit the number of patients who could be prescribed the medication. It is not clear to the DAV why usage is lower within the VA than within the private health care sector. Our concern is that these restrictions are causing the use of less costly and less effective anti-psychotic medication.

Congressman Evans to Thomas Miller



# BLINDED VETERANS ASSOCIATION

477 H STREET, NORTHWEST

• WASHINGTON D.C. 20001-2694

• (202) 371-8880

## RESPONSES TO QUESTIONS FOR THOMAS MILLER EXECUTIVE DIRECTOR BLINDED VETERANS ASSOCIATION

*1. Are you aware of any programs in the private sector that duplicate the residential program for VA blind rehabilitation programs?*

Yes, there are a number of private sector or state operated residential blind rehab programs that are attempting to duplicate the VA program. Most states operate residential blind rehabilitation centers funded by Vocational Rehabilitation appropriations. Consequently, they tend to serve only those residents of the state that are of Vocational Rehabilitation potential and therefore young healthy blind people. None of these programs are affiliated with hospitals or medical centers. They have very limited ability to monitor and manage multiple medical problems during the rehabilitative process. The blinded veteran population currently being serviced by the VA BRC tend to be much older with multiple medical problems who require monitoring and management throughout their rehabilitation experience. Private agencies find themselves in similar situations with respect to medically involved blind persons. One major national consumer organization, the National Federation of the Blind (NFB) operates its own blind rehabilitation training center. The average length of this program is nine months. All blind persons attending this program must stay for the full nine months. Private and other public sector programs do not as a rule hire university trained Blind Rehabilitation Specialists possessing Master's Degrees in Blind Rehabilitation as does the VA. These hiring qualification standards help separate VA from other programs and ensure high quality service.

*2. You identify many individual characteristics that would make it difficult to say how long an inpatient care episode should last for a veteran but certainly there are elements of the rehabilitation that take a certain time to master. Is there a floor on average length of stay that should convey to Congress that quality is being compromised?*

This is an extremely difficult question to answer. There are so many variables that impact length of stay. It is very difficult to predict the time necessary to master any given skill. There is no research to suggest a definite time period which it should take a veteran to master a certain skill. Each veteran's situation is unique. Allow me to use myself as an example. I completed the VA Blind Rehabilitation Program at the Hines BRC 30 years ago. I was totally blind as the result of a land mine explosion in Vietnam. Additionally, I had completed a B.S. degree before enlisting in the Marine Corps and was 26 years old upon admission to Hines. The average length of stay at that time was 18 weeks. I completed the program in 16 weeks and needed every bit of that time. The BRC program was primarily serving young combat disabled veterans ranging in age from 17 to their mid-20s. The majority of the veterans were totally blind and required a pre-vocational training model. For the most part those of participating in the rehab program were otherwise



healthy and aside from wounds sustained in combat did not have other medical problems that could potentially impact the length of stay. Progress in the program was influenced by educational background, physical fitness and to a certain degree athletic ability and coordination as well as the degree of adjustment to blindness. Of course there are some very basic skills that should not require much time at all to master but do not have a significant impact on length of stay. The BRC program is very demanding physically and psychologically. The more athletic or well coordinated an individual the more likely one is able to become a proficient, safe and independent traveler with the long white cane. Those who were not so disposed had more difficulty and took longer to master the same skills. This phenomena is no different for able bodied persons when it comes to mastering any skill whether it be in the field of sports or otherwise. Some individuals are born with more natural ability than others therefore requiring less practice to master certain skills

The current population of blinded veterans being served by VA BRC on average are in their 60s and have some remaining functional vision. They do not require as long a length of stay because of age, other medical conditions and degree of useful vision. Advances in low vision optics over the past 20 years have enabled people with low vision to maximize their independent functioning more easily and quickly. Here again, to my knowledge there are no studies to determine precisely how long on average it takes to master any given task. Generally, this population does not need a full blown Orientation and Mobility program.

VA Blind Rehabilitation Service is currently involved in the development of Outcome Measurement Instruments for data collection. Once these instruments have been developed, tested and refined, serious data collection can begin. Until functional outcome data has been collected and analyzed, it is difficult to determine just how effective the VA program is and if the analysis will reveal a floor below which quality is compromised. The other aspect of the basic or core program that is even more difficult to determine a prescribed length of stay that will maximize social and psychological adjustment to blindness. Successful adjustment is directly related in part to obtaining sufficient proficiency with essential skills resulting in improved self confidence as well as the opportunity to share with other blinded veterans all the problems associated with vision loss. The latter occurs as the result of living 24 hours per day, seven days per week. The residential setting also facilitates a more intensive training environment optimizing more rapid development of skill acquisition. This has been an awfully long answer without really providing a definitive response to your question.

*3. You recommend having mandatory guidelines for specialized services. Who should develop these guidelines and insure they are being implemented?*

In my view, such national guidelines should be developed by special disabilities program officials with knowledge, expertise, experience in their respective specialty areas. Adherence to these standards and guidelines should be a part of each facility and Network Directors performance standards. In the case of Blind Rehabilitation Service (BRS), there are five position across the system, Regional or National Consultants, that are charged with overseeing BRS programs for the Director of BRS in VAHQ that could be tasked with insuring they are being implemented.

4. *Dr. Fitzgerald's statement asserted that BVA has not specifically objected to bed closures at VAMC West Haven. Is this a fair statement?*

Dr. Fitzgerald is playing a game of semantics with this assertion. BVA has not specifically opposed the reduction of the number of blind rehab beds at West Haven believing the number currently authorized is too many for any one facility. We have however strongly objected to closure of blind rehab beds. We have recommended to facility and Network management transferring those 15 beds either to another facility in that Network or to another Network altogether. Please see copies of correspondence on this issue attached to these responses.

5. *What is a reasonable waiting time for inpatient admission for BRS?*

Subsequent to the Senate Veterans Affairs Committee Oversight hearing mentioned in my testimony, the Prosthetics Improvement Implementation Plan was established. Contained within that plan were specific goals and objectives for the special disabilities programs. The goal established in that plan for waiting time for admission BRS was 120 days. BVA believes this is reasonable. It is important to note this objective has been achieved at all but three of the existing nine BRC. This is largely a reflection of reduced lengths of stay accomplished by BRS in response to the changing needs of our blinded veteran population. We are aware however that many of these same host facility managers are trying to force further reductions in length of stay seeking further cost savings rather than being driven by quality.

Department of  
Veterans Affairs

Memorandum

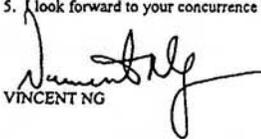
Date: MAY 21 1998

From: Director, VA Connecticut Healthcare System/00/11/950 Campbell Avenue, West Haven, CT 06516

Subj: Bed Reduction

To: Director, Blind Rehabilitation Service/117B/810 Vermont Avenue, NW, Washington, DC 20420  
THRU: Director, VA New England Healthcare System/10N1/Building 61, 200 Springs Road, Bedford, MA 01730  
WFD: DJF

1. The VA Connecticut Healthcare System has continued to maintain a total of 49 beds in our Blind Center. Originally 45 beds were designated for blind rehabilitation and 4 beds for the computer assisted training program (CAT). It is apparent that we can not adequately utilize this number of beds. The number of applications for rehab beds has dropped so that we are unable to fill 49 beds. I must emphasize that the reduction in staffed beds will not reduce capacity as legally mandated. In fiscal years 1996 and 1997, the blind center served 303 and 307 veterans respectively. The needs of an aging veteran population are better met through the design of personalized rehabilitation plans, which has resulted in shortened lengths of stay. With fewer beds we can easily serve 300 veterans a year and can increase the number, as needed, through the BROS and CAT programs.
2. The problem of low bed utilization raises several issues that we must address. Unused beds skews the cost for blind rehab so that it appears that VA Connecticut is less efficient, when compared to other blind centers. There is a more pressing need for blind rehab beds in VISNs outside of our catchment area. It is a disservice to veterans to staff empty beds in this VISN, when veterans in other VISNs may not have timely access to blind rehabilitation services.
3. I propose that we not use 15 beds; these beds would be available to be transferred to another VISN. Of the remaining 34 staffed beds at VA Connecticut, 26 would be designated for rehab and 8 for CAT. There is a long waiting list for the CAT program so that increasing the number of CAT beds will better meet the needs of blinded veterans.
4. I expect that you and the Blinded Veterans Association (BVA) will support this plan. I know that the Executive Director of the BVA, Mr. Tom Miller, has recommended that we reduce the size of the VA Connecticut program. Mr. Ron Miller, the Blinded Veterans Advocate has recommended that 15 beds be relocated to another Network.
5. I look forward to your concurrence in this, as we need to plan to meet our budget challenge for FY1999.

  
VINCENT NG

99 MAY 28 PM 12:24  
VA NEW ENGLAND  
HEALTHCARE SYSTEM  
BEDFORD, MA 01730



# BLINDED VETERANS ASSOCIATION

477 H STREET, NORTHWEST

WASHINGTON D.C. 20001-2694

(202) 371-8880

June 16, 1998

Dr. Dennis J. Fitzgerald  
 Director, VISN #1  
 150 South Huntington Avenue  
 Boston, Massachusetts 02130

Dear Dr. Fitzgerald:

I am writing in response to a letter dated May 21, 1998 from Mr. Vincent Ng through you to the Director of Blind Rehabilitation Service, (BRS), VAHQ. The subject of the letter is a proposed closure of 15 blind rehab beds located at VAMC West Haven, Connecticut. In that letter Mr. Ng states he expects the Blinded Veterans Association's, (BVA) support and that I recommended reducing the size of the VA Connecticut Blind Rehab Program.

Before responding to the assumptions outlined to justify the closure of 15 beds, I want to respond to the above mentioned statements regarding the BVA and recommendations attributed to me. Mr. Ng is presumptuous to think he can expect the support of BVA for this proposal. Other than rumors, this letter is the first time a formal proposal has been made available to BVA and therefore wide discussion of this issue has not yet taken place. Further, BVA worked very hard along with other major Veterans Service Organizations to include legislative language in the Eligibility Reform Act to protect the special disabilities programs such as blind rehab. Contained in that legislation are specific requirements for VA to maintain its capacity to provide specialized services to disabled veterans. The Under Secretary for Health has signed off on a definition of Capacity that provides that resources are defined as dollars, FTEE and beds.

We understand this definition was scheduled to be changed to the number of unique veterans and outcome measures on October 1, 1998. I have reason to believe however, this change will be delayed until the special programs have had sufficient time to develop, test, refine and validate outcome measurement instruments. It would appear this proposal anticipates having the authority on October 1, 1998 to reduce beds inasmuch as they will not be included in any definition of capacity. Therefore, it is highly unlikely BVA will support this or any other proposal calling for reduction of beds in a BRC until such time as Outcome Measurement data suggests that another rehab model will deliver the same high quality blind rehab outcomes being achieved in a comprehensive residential blind rehab center.

Regarding my recommendation to reduce the size of the VA Connecticut program, I can only suggest my comments were misunderstood or taken out of context. I believe Mr. Ng is referring to recommendations I made at the meeting of an Advisory Group convened at

## LETTER/DR. DENNIS FITZGERALD

West Haven in late September of 1996 to review and discuss his decision to relocate 15 beds from the West Haven facility to Newington, Connecticut. The relocation of the BRC beds was designed as a pilot project to test the hoptel concept for blind rehab. A number of us expressed serious concerns with this approach given the plan would not provide 24 hour nursing coverage for the blinded veterans in the program. After I visited the Newington facility and had a number of questions answered regarding emergency procedures and how ongoing medical problems would be monitored and managed during the rehab experience, I indicated in a meeting in which you attended that in my opinion the potential risks involved in this hoptel approach were acceptable. The bottom line was let's test this concept to determine if it has merit. I did however make one very strong recommendation, if it was determined not to retain the 15 bed program at Newington, do not relocate it back to the West Haven facility. Less than one week after that meeting, Mr. Ng did in fact decide to relocate those beds back to West Haven.

The basic reason for my strong negative recommendation opposing relocating the beds back to West Haven was not predicated on my feeling the size of the VA CT program should be reduced. On the contrary, my belief then and now is that the 49 beds he alludes to are too many for anyone facility to operate. Blind Rehab is unquestionably a resource intensive program and no one facility should have to bear the fiscal and resource burden of that many special disability program beds. This is especially true for the West Haven facility. Sufficient space has never been made available for the program even in its earlier years when they only had to support a 25-bed program beginning in 1969. Over the years, West Haven management has never adequately supported the BRC with sufficient space and staffing levels.

To place this argument into some historical perspective, let me explain how West Haven reached its current predicament. As mentioned above, when the West Haven BRC was established in 1969 it was a 25-bed program and in our view was not provided sufficient space for that many beds and staff. In the early 80's, a VA Blind Rehabilitation Clinic located at VAMC North Hampton, MA. was relocated to West Haven and merged into the same space as the existing BRC. In the interest of space here, I will not go into the differences between the Clinic and Center programs then in existence, but they were significant particularly with respect to sharing common space, staff and resources. Suffice it to say, that 15-bed program should never have been transferred to West Haven. BVA reluctantly agreed to that transfer only after it became clear the 15-bed program would be closed altogether if not accepted by West Haven. There have been nothing but problems ever since. The crisis in space was only magnified and the medical center has never provided sufficient space to accommodate all the blind rehab beds. Then to further exacerbate an unacceptable situation, resources were provided to West Haven in FY95 to open four (4) Computer Access Training beds. Those four beds were never in fact provided. Because of lack of space, management decided to take four beds from the basic adjustment to blindness program and use them for the CATS program. Consequently,

**LETTER/DR. DENNIS FITZGERALD**

there are not and never have been 49 blind rehab beds operational at the VAMC West Haven.

Dr. Fitzgerald, BVA is not opposed to relocating 15 beds to another medical center within VISN#1 or transferring them to another VISN interested in the residential program and capable of providing adequate support in terms of space and appropriate staffing levels. We are however absolutely opposed to the complete elimination of these program beds from the system.

BVA does not believe the difficulty in keeping blind rehab beds filled, referred to by Mr. Ng, is a function of too many beds, but rather a lack of appropriate productivity on the part of the Visual Impairment Services Team (VIST) Coordinators within Network 1 and from referring Networks. VA statistical data strongly suggests there are more than sufficient numbers of blinded veterans in the West Haven BRC catchment area to keep the beds filled in addition to maintaining a reasonable waiting list for admission. Further, we believe that the Regional Consultants assigned to the BRC have not been productive in properly educating, encouraging and motivating these VIST Coordinators regarding the benefits of VA Blind Rehabilitation Services. Review and oversight of the VIST program is the single most important element of the Regional Consultant's duties and referral patterns clearly reflect they have not been meeting their responsibilities. It seems clear to BVA that a comprehensive review of referral patterns and levels of productivity should be undertaken in an effort to uncover barriers or perceived barriers to referral for Blind Rehab Training at the West Haven BRC.

We also have serious problems with the allegations that the facility can maintain the same capacity despite closing 15 beds. Mr. Ng argues the older veteran population needs are more limited and the provision of more individualized rehab has resulted in significant reduction in the length of stay. Therefore, he concludes they can indeed increase the numbers of rehab episodes with a reduced number of beds thus maintaining capacity. While we do not disagree the changing needs of an older blinded veteran population has resulted in shorter rehab programs, we are deeply concerned these same arguments are being used to apply inappropriate pressure on rehab professionals to reduce lengths of stay even more. In our view this will certainly compromise quality of care. The only determinate to length of stay should be the veterans needs and his/her ability to learn and progress comfortably through the training until all needs have been adequately addressed. To do any less will not achieve desired functional outcomes or result in healthy adjustment to sight loss. Cost driven, arbitrarily mandated lengths of rehab stays must not be tolerated.

One of the most extraordinary aspects of the residential blind rehab program is the opportunity this environment provides to develop healthy attitudes towards blindness essential to successful acceptance of and adjustment to vision loss. Experience has

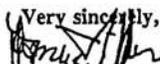
## LETTER/DR. DENNIS FITZGERALD

demonstrated that the degree of loss has little bearing. Often veterans who retain some usable vision are just as devastated over this loss as individuals who have experienced total blindness. Currently, outcome data does not exist to suggest outpatient blind rehabilitation or any other rehab delivery model achieves the same high quality functional and adjustment outcomes characteristic of VA comprehensive residential blind rehabilitation. Until such time as alternative models of blind rehab delivery are tested and can demonstrate they can match the residential program with respect to outcomes, unrealistic and arbitrary lengths of stay should be prohibited.

Dr. Fitzgerald, it is our distinct impression that such unrealistic demands are being placed on the West Haven BRC. Further reductions in length of stay, over the present, will be absolutely necessary to reinforce the argument they can maintain capacity by treating the same number or more of blinded veterans despite closing 15 beds.

In closing Dr. Fitzgerald, BVA believes the proposed reduction in the number of blind rehab beds at the West Haven facility would be a breach of congressional intent and is a very serious step requiring more discussion and planning. Again, BVA is not opposed to relocating those beds to another facility within VISN#1 or another Network. Additionally, we are anxious to participate in any planning regarding the future of blind rehabilitation in Network 1.

Thank you in advance for your careful consideration of our concerns.

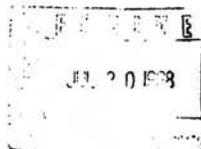
Very sincerely,  


Thomas H. Miller  
Executive Director

THM:am



DEPARTMENT OF VETERANS AFFAIRS  
 VA New England Healthcare System  
 Network Office, Building 61  
 200 Springs Road  
 Bedford, Massachusetts 01730



July 10, 1998

In Reply Refer To: 10N1

Mr. Thomas H. Miller  
 Executive Director  
 Blinded Veterans Association  
 477 H Street  
 Washington, DC 20001 - 2694

Dear Mr. Miller:

I am writing in response to your letter dated June 16, 1998, concerning the reduction of Blind Center beds at VA Connecticut to a total of 34. Let me assure you that this is a proposal and not a plan. Mr. Vincent Ng's letter was written at the request of Mr. Don Garner. Mr. Garner asked that the proposal be put in writing so that he could share it with the Blinded Veterans Association for input. I agree completely with your statement that this is a very serious step requiring much more discussion and planning.

I hope that the BVA would be actively involved in the planning process. It is not our intent to reduce capacity but to consider relocating 15 beds to another geographic region where they would better serve the needs of veterans. As you mention in your letter, 49 beds are too many for one facility to operate. It is a resource intensive program and, as you say, a burden for one facility to operate so many beds. In this regard I hope that BVA would work with me in helping to identify a Network that would welcome 15 blind rehabilitation beds.

As Mr. Ng mentions in his letter, we are having difficulty filling all of the rehab beds. I agree that part of the issue is the level of productivity of the referring VIST Coordinators. I am eager to fill the Regional Consultant position that was vacated by Mr. Ed Lay so that the VIST Coordinators' productivity is being monitored.

Veterans from a wide geographic area come to the Blind Center at VA Connecticut and make excellent use of the therapeutic milieu. However, many veterans are reluctant to travel far from home and family to partake in the program. Some veterans arrive and have great difficulty participating because of debilitating medical conditions and at times they request to be discharged home before completing the program. For these reasons it is essential that together we look at modification to the design of the program that will be related to objective outcome measures and will enhance rather than diminish capacity.

Veterans Integrated Service Network (VISN 1)  
 Massachusetts: Boston, Bedford, Brockton/West Roxbury, Northampton. New Hampshire: Manchester.  
 Connecticut: VA Connecticut. Vermont: White River Junction. Rhode Island: Providence. Maine: Togus

Mr. Thomas Miller  
July 10, 1998

As you know, Mr. Vincent Ng has left to be Director of VISN 14 in Omaha, Nebraska. In the interim Mr. Paul McCool is Acting Director. Any further planning or proposed programmatic changes for the Blind Center at VA Connecticut will be deferred until a permanent Director is appointed. Once the Director is appointed it is my intent to invite the BVA to be actively involved in the planning process.



Denis J. Fitzgerald, MD, MHA  
Network Director, VISN 1  
VA New England Healthcare System

Congressman Evans to Thomas Miller

**VA Federal Advisory  
Committee on  
Prosthetics and Special-  
Disabilities Programs**

Thomas H. Miller, Chairman Address: Blinded Veterans Association,  
477 H Street, N.W., Washington, DC 20001  
Phone #202/371-8860, Fax # 202/371-8258

**RESPONSES TO QUESTIONS FOR THOMAS MILLER, CHAIRMAN  
VA FEDERAL ADVISORY COMMITTEE ON PROSTHETICS AND SPECIAL  
DISABILITIES PROGRAMS**

1. *Mr. Miller, do you believe the VA data that shows delayed prosthetics order constitutes less than 2% of all processed by VA?*

I have serious doubts this is the case. This response is based on information I and two other members of the Advisory Committee received while attending a meeting with all Prosthetic Representatives in June of this year. We received reports that some Representatives were being told not to report delayed orders. In a few cases others alleged that the reports that were forwarded to their facility management were in fact changed before being sent to VAHQ. I realize this is anecdotal information and I do not have hard data to support this belief.

2. *Your statement seems to recommend VA needs centralized funding for prosthetics. Are there any other ways you could identify that would insure that VA has a successful program?*

The fundamental concern of the Advisory Committee is that dollars appropriated and allocated for the provision of timely high quality prosthetic services is whether these dollars are indeed being spent on the provision of such services. Prior to the Senate Committee on Veterans Affairs Oversight Hearing in June 1990, substantial evidence existed to demonstrate that medical center managers were in fact not using these funds for prosthetics but for other services. This led to centralized funding of these services.

Prosthetics & Sensory Aids Service (PSAS) in VAHQ now possess a very powerful electronic database tool for tracking the cost of prosthetics services. It also tracks the best practices in the provision of these services as well as just what devices were provided, to whom and from which vendor the device was purchased. Unfortunately, severe reductions in personnel in PSAS VAHQ including the loss of the computer consultant position that was providing the technical support have compromised the services ability to roll up, collect and analyze the data. It would appear that if all these FTEE were restored, PSAS would have sufficient ability to satisfactorily track the allocation of prosthetic funding. The one problem that remains however, is that once the decentralization of prosthetic funding to the Network level has occurred, each Network has the flexibility to allocate those funds to the various facilities within the network as it sees fit. The lack of uniformity or consistency in this regard complicates the ability to track dollars.

*3. What do you believe will happen when Prosthetic programs run out of money this quarter?*

There will be a significant increase in delayed orders resulting in veterans having to wait for essential services until the new fiscal year or the medical managers will take money from other programs and services to fulfill their promise to insure the provision of prosthetic services. I believe the latter scenario is the most likely given the program's high visibility not only because of this Oversight Hearing but the Eligibility Reform Act adopted two years ago. VHA did not request sufficient funding levels for Prosthetic Services nor did they adequately anticipate the impact of the Eligibility Reform Act and the expanding demands for prosthetics this would guarantee. It is the Committee's understanding that PSAS did request a substantially higher budget request in an effort to anticipate this increased work load but the Under Secretary cut that request back. It is truly unfortunate that in order to provide timely high quality prosthetic services, reductions in other programs and services will be necessary. Proper prioritization of Prosthetic Services in developing the budget submission for VHA does not appear to have taken place.

*4. Have you received a response to your letter to Dr. Kizer expressing some of my serious concerns about the prosthetics program?*

No, I have not yet received a response to that letter which I had attached to the written statement submitted for the record of the Hearing. Not receiving a timely response from VHA officials is a chronic problem for the Advisory Committee. All too frequently, letters are unresponsive failing to adequately address issues raised in correspondence and top managers seem unwilling to make appropriate decisions when policies are in question.

*5. Tell us what you think will happen if the Prosthetics Services continue to be dismantled at the facility and Network level?*

The Advisory Committee is gravely concerned that should these services continue to be dismantled at the facility and or Network level the quality of service will certainly decline. As Network and facility managers struggle to identify cost savings, clinical and programmatic decisions are being made by budgeteers rather than the clinicians providing the essential care to severely disabled veterans. Consequently, streamlining, realignment and reorganization seem to be driven more by cost rather than quality service. If highly qualified Prosthetic services and their representatives are indeed dismantled, where will the clinical expertise come from to insure the provision of these essential services? As these Services are dismantled or otherwise cut back, remaining personnel are being asked to do more with less and it is only a matter of time before burn out will further compromise the quality of service delivery. Many Prosthetic Representatives and Prosthetics Purchasing Agents (PA) are working incredible overtime hours both compensated and voluntary. How long before they will either quit or look for other employment? Transferring the responsibilities of the Prosthetic PA to other employees in the medical center will also result in reduced quality and timeliness of service delivery. There appears to be at least in some Networks and facilities a total lack of respect for the professional knowledge, experience and expertise possessed by this clinical service. Reorganization and or realignment need not result in the above mentioned loss of ability to provide quality services. It is imperative the integrity of the Service must be maintained under whatever organizational structure is implemented.

6. *Your claim that some prosthetics representatives are being told not to report delays in purchasing or having the data they reported altered by superiors is one of the most serious allegations in the testimony. How did you collect this information? Does it correspond to what you know of the Prosthetics Service?*

As mentioned in an earlier question, three VSO representatives on the Prosthetic Advisory Committee had the opportunity to attend a national training program of all Prosthetic Representative and those professionals in Physical Medicine and Rehabilitation Service (PM &R) involved in the Spinal Cord Injury (SCI) program conducted in Orlando, Fla. in June, 1998. During this program, we had the opportunity to meet exclusively with only the prosthetic representatives. These individuals shared with us the problems they are confronting at the local levels and the extent of their frustrations. It was during this session, some revealed they were indeed being instructed not to report delayed orders and in some cases they had the occasion to see reports they had forwarded to management and observe the figure had been altered. Neither I nor any of the other VSO members of the committee had an opportunity to see such reports and must rely on reports from individuals involved. We agree these are very serious allegations and if they are indeed occurring, cannot be tolerated.

It is impossible for me to say this corresponds with what I know about Prosthetic Service. I do know that PSAS in VAHQ is having great difficulty in receiving the delays order reports that are required to be submitted on a monthly basis from some facilities. This certainly suggests potential problems with data collection or altering data at the local level. While on this point regarding submission and analyzing these reports at HQ, here again staffing cut backs in HQ have resulted in quarterly reports being tabulated. Staffing shortages does no longer permit doing a national report on a monthly basis. Consequently, any upward trend in delays may go unnoticed for longer than is prudent to take appropriate corrective action.

RESPONSE BY  
 DR. RICHARD KRUGMAN,  
 Dean, University of Colorado School of Medicine  
 Representing The AAMC

**QUESTIONS FROM:**

Mr. Lane Evans  
 Post-Hearing Questions  
 Committee on Veterans' Affairs  
 Subcommittee on Health

- 1) *Dr. Krugman, has the added layer of VISN management made your relationship with the Denver VA Medical Center easier or harder? Please elaborate.*

The added layer of VISN management has made the relationship with the VAMC Denver neither easier or harder. It has made it different. Notably, it has provided for greater regional autonomy in our planning for the academic mission in this area of the country.

- 2) *Dr. Krugman, how have residency placements been affected at your facility in recent years? Has there been a noticeable transfer of residents to outpatient settings? To primary rather than specialty care? Do VA's placements continue to gibe with the University's training requirements for its students?*

At the Denver VA Medical Center the absolute number of resident trainees has declined slightly over the past three years by three positions. However, the change in specialty distribution of these residents has been more substantial. Primary care residents have increased by 10 and specialty-subspecialty positions have fallen by 13. The trend is similar to that seen generally at university medical center programs. Student programs also have been adjusted to increase the outpatient care experience.

- 3) *You allude to a need for VA to ensure that the medical care budget continues to fund research support. In other places, we have heard that operating under VISNs has somewhat changed these practices. Has there been a change in VA's commitment to research support under the new management structure? Please elaborate.*

Total VHA direct research grant support hopefully will increase from \$272 million in fiscal year 1998 to \$300 million for fiscal year 1999. The model used to fund individual VISNs (VERA) allows for matching indirect funds to be passed on to these VISNs based on the direct grant support generated by facilities within the VISN. These indirect funds are placed in the medical care budgets. The basis for their distribution to individual VA facilities within VISNs is highly variable. Some pass the moneys through directly to facilities based on their direct grant support, others do not. Thus, the level of individual VISN research support is mixed.

It is very important that an environment in which education and research can flourish be sustained. Whether this can be accomplished will be determined by the availability of time and money. It is therefore very important that VISN directors and medical center directors place a priority on research and education. Judging by what I have heard from my colleagues around the country, the experience is quite variable.

- 4) *In your view, has VA revised its requirements for supervising residents recently? Is it easier, harder or the same for supervising physicians?*

Residency supervision is fundamentally the same. The shift to more outpatient exposure, however, has changed the format to one of more immediate feedback and teaching focused on individual patients in this ambulatory setting. I understand that the Office of Academic Affiliation at VA National Headquarters is convening an advisory group to update VHA's policy regarding resident supervision. The AAMC will have representation in that activity so I feel assured that our interest will be represented.

- 5) *In your view, has VA revised its requirements for obtaining VA research grants recently? Is it easier, harder or the same for physician-researchers?*

In the mid-1990's VA merit review grants were among the most difficult peer-reviewed grants to obtain with funding at the 15<sup>th</sup> percentile (equivalent to NIH RO1 grant). However, in the past year with increased funding available, VA merit review grants are being funded in the 20<sup>th</sup> to 25<sup>th</sup> percentile. This trend is also occurring with NIH peer-reviewed funding.

- 6) *Do you see any new needs emerging in VA or the veterans' population that you envision VA and academic affiliates could collaborate in fulfilling? Needs for research? Needs for new types of specialists?*

There are always opportunities for new collaborations between VHA and academic affiliates. These exist in patient care, research and education missions. These include additional sharing agreements for subspecialty care, contracting for community based primary care clinics, further integration of the elements of student and housestaff training and joint efforts in solving space and resource challenges in research - particularly in relation to the private sector and industry.

There are also opportunities afforded by the pressures of change in the current healthcare environment. Two examples of collaboration between VA and its academic affiliates in this regard are the VA's Primary Specialist Program and the recent Robert Wood Johnson Foundation-funded initiative in improving resident education for care of patients at the end of life.

This year VA has initiated the Primary Specialist training program for subspecialty resident trainees in over 50 VA medical centers throughout the country. This program puts particular emphasis on training for the expert management of chronically seriously ill patients while it focuses on primary care issues such as health maintenance, disease prevention, and the provision of continuous, comprehensive, coordinated and accessible care. It will involve nearly half the medical and psychiatric subspecialty residents who receive training in VA. It is founded on the principle that primary care is not limited to a given set of specialties but rather is a *method of patient care delivery*.

The VA Faculty Leadership Project for Improved Care at the End of Life was initiated to develop benchmark curricula for end-of-life and palliative care for resident physicians in general internal medicine and the subspecialties of internal medicine. The Project has been made possible by a grant from the Robert Wood Johnson Foundation. The project, which is being launched this summer, will support internal medicine faculty at up to 30 selected residency training programs.

These are two examples of the potential synergy between VA and academic affiliates that can provide opportunities for improved care of veterans and improvement of training for the future generation of physicians in VA facilities.

