RESTRUCTURING VA MEDICAL SERVICES: MEASURING AND MAINTAINING QUALITY OF CARE

HEARING

BEFORE THE

SUBCOMMITTEE ON HUMAN RESOURCES

OF THE

COMMITTEE ON GOVERNMENT REFORM AND OVERSIGHT

HOUSE OF REPRESENTATIVES

ONE HUNDRED FIFTH CONGRESS

SECOND SESSION

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RESTRUCTURING VA MEDICAL SERVICES: MEASURING AND MAINTAINING QUALITY OF CARE

FRIDAY, SEPTEMBER 25, 1998

HOUSE OF REPRESENTATIVES,
SUBCOMMITTEE ON HUMAN RESOURCES,
COMMITTEE ON GOVERNMENT REFORM AND OVERSIGHT,
Washington, DC.

The subcommittee met, pursuant to notice, at 10:36 a.m., in room 2154, Rayburn House Office Building, Hon. Christopher Shays (chairman of the subcommittee) presiding.

Present: Representatives Shays, Gilman, Towns, and Allen.

Staff present: Lawrence J. Halloran, staff director and counsel; Robert Newman, professional staff member; Jesse S. Bushman, clerk; and Cherri Branson, minority counsel.

Mr. SHAYS. I'd like to call this hearing to order, to welcome our witnesses, to welcome our guests. I tell you that this is going to be a very interesting hearing. We're grateful to have everyone here.

This is the subcommittee's second hearing on the impact of reorganization and funding shifts on the quality of care in the Department of Veterans Affairs health system.

In August of last year, we heard testimony from VA officials and veterans in Middletown, NY—I will never forget that hearing—in response to our colleague, Ben Gilman's, concerns that budget-driven staff reductions and facility consolidations are limiting access, undermining quality, and endangering lives at local VA hospitals.

Today, we examine similar concerns brought to our attention by our subcommittee colleague, Mr. Allen of Maine. That State's entire congressional delegation has been pressing the VA for action on a growing volume of complaints about the quality of care at the Togus Veterans' Administration medical center in Augusta. Veterans report intolerably long waits for access to specialists, critical staff shortages, uncoordinated care, inequitable distribution of declining budget resources under the Veterans' Equitable Resource Allocation Bureau system.

In Connecticut, we have the same concerns. Our facilities are part of the same Veterans' Integrated Service Network. And we, too, have felt VERA's physical wrath. In July, the Connecticut congressional delegation called VA Secretary Togo West to ensure more equitable application of their VERA plan within, as well as between regions. Like other attempts to control health care costs, notably the Medicare home health interim payment system, VERA

in New England has punished efficiency, rewarded inefficiency, and provided few, if any, incentives for quality over quantity of care.

As an oversight subcommittee, our charge is the overall economy, efficiency, and management of human service programs, including VA health care. We convene here today because an 18 month wait for new dentures is not efficient. Requiring elderly veterans to travel hundreds of miles for routine diagnostic tests is false, even cruel economy. Staff shortages and poorly coordinated care point to bad management.

What do we expect from this hearing? We expect candor, not canned speeches about the failure to integrate inefficient Boston facilities, and the price Connecticut and Maine continue to pay for this delay. We need to know the bottom line, not the company line on future VERA budgets, and the true cost of providing care where the veteran needs it, not hundreds of miles away where the network offers it.

And on behalf of those who served, we demand to know that once proud facilities like Togus and West Haven will not be consigned to a slow, withering decline by bureaucratic léger demain, but will again shine as beacons of comfort to those in need.

Again, I welcome our guests. And I will just say again for the record that it is insane to reward inefficiency and to punish efficiency; and it is insane to have some facilities be inefficient and cost other facilities a high price.

At this time, I call on Mr. Towns or Mr. Allen, whichever of you would like to go first. Mr. Towns.

Mr. TOWNS. Well, actually I would like to just yield to my colleague because this way we can get it in. And I will probably just put my statement in the record. This way we'll be able to do this before going to vote. I'd like to yield to my colleague.

[The prepared statement of Hon. Edolphus Towns follows:]

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INDEPENDENT

OPENING STATEMENT OF
REP. EDOLPHUS TOWNS, RANKING MEMBER
SUBCOMMITTEE ON HUMAN RESOURCES
SEPTEMBER 25, 1998

Mr. Chairman, thank you for holding today's hearing on the Department of Veterans' Affairs health care system. The vast majority of patients who routinely visit VA facilities are indigent or have disabilities incurred or aggravated during their military service. On average, VA's patient population is older, sicker, and poorer than patients served by other health care providers.

Congress and the Administration have adopted two basic strategies for addressing the problems of access, efficiency, and effectiveness in the VA health care system. First, VA will shift resources through the Veterans Integrated Service Networks. Each VISN manages all resources within a region. According to the plan, VISN will increase efficiency and decrease costs because of savings achieved through the elimination and duplication in administrative overhead. Second, VA will employ an extensive quality assurance program. The goal of the program is to assure that each hospital can render quality care.

This two-pronged approach sounds like an idea that will work. However, in the Northeast, we have found that services have been reduced, hospitals and outpatient clinics have been closed and staffing problems have lead to complaints about the quality of care for the average veteran. Mr. Chairman, while I believe that we should always strive for economy and efficiency, I do not believe that we should sacrifice the health care of veterans.

I look forward to hearing the testimony of our witnesses today and look forward to working with you and all interested Members in assuring that veterans who live in the Northeast retain access to quality VA health care services.

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Mr. ALLEN. I thank the gentleman for yielding. Thank you, Mr. Chairman, and good morning to all our witnesses. First, I would like to thank the chairman and Congressman Towns for arranging this hearing, and inviting witnesses from the Veterans' Administration, Togus VA Medical Center, and veteran representatives from my home State of Maine. I want to thank Dr. Garthwaite, Dr. Wilson, Mr. Ng, Dr. FitzGerald, and Mr. Sims for appearing here today. And I would like to welcome the other main witnesses: Dr. Woolett, Dr. Bachman, and Mr. Williams to Washington and to our subcommittee.

I would also like to thank those who have helped me understand the situation at Togus, including Norman Nual and Gary Burns of the Disabled American Veterans; Bert LaFrance of the Military Order of the Purple Heart; Helen Handlin, from the Association of Federal Government Employees, Bill Powers from the American Legion, and George Bragg from the Veterans of Foreign Wars.

I also want to welcome my friend and colleague, John Baldacci, to our subcommittee.

Our veterans have served this country courageously and honorably. Some gave the ultimate sacrifice in defense of America, while others now struggle with service-connected health problems. Taking care of our veterans should be a top national priority. Unfortunately, I am not convinced that this is always the case.

As a delegation, Maine's Senators and Representatives spend more time together on the Togus VA Hospital than any other issue. It is an important institution to our veterans in Maine, and it must provide quality care. Togus has made great strides in some areas, such as reducing some waiting times, establishing additional community-based clinics, and recently, contracting out MRI services. However, there is much more that needs to be done. My office is inundated weekly with complaints from veterans and their families. These complaints still include long waiting times; long trips to Boston for care, often after a long trip to get to Togus; inadequate time spent with doctors; and poor quality of care.

The veterans that I have talked to who use Togus services are generally supportive of Togus' staff, the doctors and nurses. They tell me that most of the staff are caring and truly want to do what is best for the patient. But they also tell me that the staff is overworked, and sometimes hampered by a system that does not always allow them to do the best they can. Veterans are upset about the reorganizations and consolidations being made in Maine. They perceive a deterioration in services, and they fault the VA for making budget cuts a higher priority than patient care.

After listening to veterans and VA officials over the past year and a half, I am not convinced that managed care or out-patient, instead of in-patient care, is the right direction for the VA. I am also not convinced that the VERA funding model is fair to individual VA hospitals. I see a rise in the workload at Togus, but real dollar decreases in its budget. Can the VA adapt to the current funding level, or is it simply not able to provide needed services without budget increases? In Maine, there's an old joke about the native Mainer who tells a tourist: "You can't get there from here." I'm beginning to believe that we can't get to quality health care for Maine veterans on the current VA VISN–1 and Togus budgets.

I hope today to learn about more of the impacts of the organizational and financial changes the VA is going through. I hope to find out how the VA and in particular VISN–1 and Togus Hospital will improve services to our Maine veterans and what more needs to be done. I realize this is a difficult task, but I hope we can learn today how to work together and ensure all our veterans are treated with respect, and get the health care they need and have earned.

I thank you, Mr. Chairman.

[The prepared statement of Hon. Thomas H. Allen follows:]

Opening Statement by Representative Tom Allen (ME)
before the Subcommittee on Human Resources
Committee on Government Reform and Oversight
September 25, 1998
Quality of VA Health Care

Thank you, Mr. Chairman, and good morning. First, I would like to thank you and Congressman Towns for arranging this hearing and inviting witnesses from the Veterans Administration, the Togus VA Medical Center, and veterans representatives from my home state of Maine. I want to thank Dr. Garthwaite, Dr. Wilson, Mr. Ng, Dr. FitzGerald, and Mr. Sims for appearing here today and I would like to welcome the other Maine witnesses, Dr. Woolett, Mr. Bachman and Mr. Williams, to Washington and to our subcommittee. I would also like to those that have helped me to understand the situation at Togus VA Medical Center including Norman Newell and Gary Burns of the Disabled American Veterans, Bert LaFrance of the Military Order of the Purple Heart, Helen Hanlon from the Association of Federal Government Employees, Bill Powers from the American Legion and George Bragg from the Veterans of Foreign Wars. I also want to welcome my friend and colleague, John Baldacci, to our Subcommittee.

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much more that needs to be done. My office is inundated weekly with complaints from veterans and their families. These complaints still include long waiting times, long trips to Boston for care, often after a long trip to get to Togus, inadequate time spent with doctors, and poor quality of care.

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Veterans are upset about the reorganizations and consolidations being made in Maine. They perceive a deterioration in services and they fault the VA for making budget cuts a higher priority than patient care. After listening to veterans and VA officials over the past year and a half, I am not convinced that going to managed care, or outpatient instead of inpatient, is the right direction for the VA. I am also not convinced that the VERA funding model is fair to individual VA hospitals. I see a rise in the workload at Togus, but real dollar decreases in its budget. Can the VA adapt to the current funding levels or is it simply not able to provide needed services without budget increases?

In Maine, there is an old joke about the native Mainer who tells a tourist "You can't get there from here!" I am beginning to believe that we can't get to quality health care for Maine veternas on the current VA, VISN 1, and Togus budgets.

I hope today to learn more about the impacts of the organizational and financial changes the VA is going through. I hope to find out how the VA, and in particular VISN 1 and Togus Hospital, will improve services to our Maine veterans, and what more needs to be done. I realize that

improving services while facing a flat budget is difficult and perhaps impossible. I hope that we can learn today how we can work together to ensure all our veterans are treated with respect and get the health care they need and have earned.

Mr. SHAYS. Thank you, Mr. Allen. Mr. Towns, you still have the floor.

Mr. TOWNS. Right. Thank you very much, Mr. Chairman. Let me just say this, and I'm going to yield to my colleague from Maine. You know I agree with you. This is insane. While I believe that we should always strive to cut costs and encourage efficiency, I do not believe that we should sacrifice the health care of veterans. And that appears to be happening under this structure. We owe our veterans a lot more than this. They provided service to this country, and then all of a sudden they come to this point in time and have to be concerned about their health care. To me, that just does not make a lot of sense.

And I want to congratulate you on moving forward with this hearing. And I also want to congratulate my colleague, Mr. Allen, for pushing to make certain that the people in his area are protected in the way they should be. So at this time, I'd like to yield to my colleague from Maine.

Mr. BALDACCI. Thank you very much. I would like to thank Chairman Shays, Ranking Member Towns, and Representative Allen for coordinating this hearing, and for all the witnesses that are here and the staff involvement in working with all of the witnesses. Mr. Chairman, your efforts to try to bring about some renewed commitment and sense of participation of America within campaign finance reform, and some reintroduction to the political process; and try to, at the same time, remember while we're dealing with our veterans here, we're trying to make sure they don't become cynical, their families and future generations become cynical in that even though we did promise them health care, that we pull the rug out from under them when they come back from their service. And I think if we're ever going to instill in the young people today, and in veterans and their families today that their country is going to keep their promise, I think this hearing is going to underline that important fact.

I'm pleased to be here. Veterans make up 17 to 18 percent of our State's population. As Congressman Allen said, a lot of our time as a delegation is spent in reviewing these issues. Veterans' health care and the quality of that health care is very important to all of us. And nothing is more important to the veterans and their families than to make sure that they get the best available care.

The veterans population is older and sicker and has less resources than the general population. The mission of the VA health care system must put the quality and accessibility of health care above mere efficiency of Federal resources. Staff cuts in VA medical facilities, I'm told are part and parcel of the change from in-patient care to a focus on out-patient care. I'm concerned that we may be reaching a point at Togus in regards to staffing and the present backlogs for appointments, coupled with the decrease in medical and staff support, which may lead to a serious decrease in quality of available health care.

Mr. Chairman, my father had pancreatic cancer. My father visited Dana Fiber in Boston and was told that the protocols that were available to him would be available in a local hospital, and he didn't need to travel to Boston to get those protocols, and his family didn't need to follow him down there and worry about stay-

ing in a hotel. And in our facility with our veterans, they are forced on a weekly basis to travel to Boston to get radiation therapy that would be immensely available to them. And for somebody to have bone cancer radiation treatments and to travel on some of the roads in Maine—and Maine does have some roads that do have some bumps in them—and traveling in an ambulance on the way to Boston is to me probably the most inhumane thing we could possibly do to any person regardless of whether they were a veteran or not. And I would hope that we would be able to set the policies and structures, whatever they may happen to be administratively between Washington and the region, to make sure that the veterans come first, and to make sure that the quality of care and the accessibility of care is something that is addressed. For someone to travel 250 miles to be able to have a routine physical examination or an MRI or routine radiation therapy on a weekly basis, to me is something we must work against because we know how important it is that they be closest to their families.

So these things are of grave concern to me; and I applaud the work of this subcommittee, and will work with you and our veteran populations to make sure that we reverse this trend and make sure that quality health care and the health care of our veterans comes first.

So I'd like to thank you, Mr. Chairman, and I would like to be able to submit this statement for the record.

[The prepared statement of Hon. John E. Baldacci follows:]

Representative John E. Baldacci
Opening Statement

Mr. Chairman, Members of the Subcommittee:

I thank you for calling this hearing to address concerns regarding accessibility and quality of health care for Maine veterans at Togus VA. There exists in the veterans population of Maine a very real concern that health care quality at Togus is suffering from cutbacks and recent restructuring in VA Healthcare.

Over the course of the past year the Maine Delegation Members and staff have held numerous meetings with VA, VISN 1 and Togus officials, as well as with VSO's Togus staff, and individual veterans. There have been improvements made in some areas. Specific concerns that continue to be issues for the Delegation, I believe, involve persistent vacancies of staff positions, causing long delays in care; continued referrals for care outside of the state; and the equitable allocation of resources within VISN 1 and throughout the country.

The veterans population is older, sicker and has less resources than the general population. The mission of the VA healthcare system must be to put quality and accessibility of health care above mere efficiency of federal resources.

Staff cuts in VA medical facilities, I am told, is part and parcel of the change from inpatient care to a focus on outpatient care. I am concerned that we may be reaching a "tip point" at Togus VA in regards to staffing, and that the present backlogs for appointments, coupled with a decrease in medical and support staff, may lead to a serious decrease in quality of available care.

Of grave concern to me are the numbers of veterans who are referred for services to Boston and other VISN 1 facilities. A recent agreement, through contracting out of services, allows Maine veterans to receive MRIs in state. I applaud this decision,

and would ask that VISN 1 officials aggressively seek out arrangements for other services to be contracted through local providers. Maine is, in geographic terms, nearly equal in size to the rest of the New England states put together. I ask the VISN 1 officials to recognize the great difficulty facing Maine veterans who must travel sometimes great distances to get to Togus for care. To then have to travel to Boston, another four hours away for services, is in my view excessive. I am also concerned about the burdens faced by family members who wish to be with their loved ones needing serious medical care when a trip to Boston is required.

During this session of Congress the members of the Maine delegation have addressed issues of funding for VA healthcare in general, and the VERA allocation system and Togus funding specifically. Changes made in the delivery of VA healthcare have apparently increased efficiency. However, the recent report conducted by the GAO on the VERA allocation system states that the VA does not know if VERA is ensuring equitable access. This holds true for both on the national level between VISNs and at the VISN level between facilities. This deeply concerns me, and it is my hope today to learn how VISN 1 specifically addresses equitable allocation of resources between its facilities.

I wish to thank the Members of the subcommittee and the witnesses for their participation in this hearing. I hope that through these proceedings we will address ways to improve the availability, accessibility and quality of health care offered to veterans now and for the future.

Mr. SHAYS. John, it's nice to have you here, and you're welcome to participate in the entire hearing if the time permits. I know you have other plans as well, but we have a 5 minute warning. We're going to go and vote. We have another 5 minute vote after, so I suspect it's probably going to be about a 15 minute process if you want to get something to drink or something. And we'll see you back here a little after 11. Thank you, we're at recess.

[Recess.]

Mr. SHAYS. Call this hearing to order. I would first like to ask unanimous consent that all Members of the subcommittee be permitted to place an opening statement in the record, and that the record remain open for 3 days for that purpose. And without objection, so ordered. I ask further unanimous consent that all Members be permitted to include their written statements in the record. And without objection, so ordered. And I'm also asking unanimous consent to include in the hearing record, written statements from Senator Christopher Dodd, Senator Olympia Snowe, Senator Susan Collins, Representative Sam Gejdenson, Representative Rosa DeLauro, the Yale University School of Medicine, the American Federation of Government Employees, as well as copies of letters to Secretary West from the Coalition of Northeast Governors, and the Connecticut congressional delegation. And without objection, so ordered.

[The information referred to follows:]

Statement of Senator Christopher Dodd
Veterans Administration Health Care
September 25, 1998

I want to thank the subcommittee Chairman Chris Shays for holding this hearing and once again focusing attention on veterans health care. The issues that will be addressed today are those that face our veterans every time they visit a VA Medical Center for treatment. We have an obligation to ensure that this nation's veterans receive quality medical care whether they live in West Haven or Phoenix.

Connecticut's West Haven and Newington Medical Centers have operated under severe budget constraints for the last two years. Year after year, as these facilities face cut-backs in services to veterans, it is important that we examine why these VA Connecticut facilities are in this position and what can be done to ensure that valuable services are not stripped away in the name of so-called efficiency or cost-consciousness.

In some respects, the limited funds for VA Connecticut are the result of factors beyond the control of officials at Veterans Integrated Service Network (VISN) 1 who oversee VA health care in a six-state Northeast region of the country. The absence of increases in the federal budget for veterans health care surely has had an impact on VA medical centers throughout the country, and the facilities in VISN 1 are no different. Due to the limited budget for veterans health care nationwide over the past couple of years, VISN 1 has had no real hope of an increase in its budget.

Unfortunately, the implementation of the Veterans Equitable Resource Allocation (VERA) is an equally unfavorable development which also affects every VA facility in the country. Since it went into effect, VERA has reduced the VISN 1 budget by about $50 million,

or six percent. VERA, which is just a mathematical formula, basically shifts veterans health funding from the Northeast and Midwest to the population centers of the South and West. The formula forces medical centers to focus on a turnstile method of care – bring in as many suffering veterans as possible to get credit for serving them, but push them out as quickly as possible to free space for others. The formula provides no incentive for quality and it punishes medical centers for treating veterans who make repeat visits. Worse, it punishes centers for treating veterans who have conditions that require long-term treatment.

I will work to raise federal funding for veterans health care in coming years. I will also work to try to make the VERA formula function in a way that produces quality services rather than conveyer belt operations. Such changes would benefit VISN 1 and VA Connecticut, but those changes will take time and our veterans need fixes now. It is important for us to ensure first of all that funds within VISN 1 are being distributed fairly and equitably. With regard to that issue, there are legitimate questions.

Well before the budget problems began for VISN 1, Vincent Ng, the director of VA Connecticut, began to cut costs and eliminate inefficiencies at the West Haven and Newington facilities. Those two facilities effectively became one as the director consolidated duplicate services. So VA Connecticut took the initiative early on to tighten its belt before limited budgets threatened services. Because VISN 1 distributes the funds to VA facilities in the Northeast, VISN 1 has benefitted from the savings that VA Connecticut accrued.

Four VISN 1 facilities in the Boston area, all within a 30 mile radius, had the similar duplication of services that West Haven and Newington consolidated. Yet today, nearly two years after VA Connecticut integrated its facilities, the facilities in the Boston area still have not made some basic, easy consolidations.

Despite VISN 1's smaller budget and the need for all facilities to become more efficient, there has been a resistance to consolidation in Boston from the outset. Such resistance stands in stark contrast to the VA Connecticut facilities which cut costs on their own accord. In fact, any consolidation in Boston seems to proceed at an agonizingly slow pace.

I appreciate Dr. Kizer's recent decision to integrate two of the Boston facilities. Frankly, however, two years was too long to wait for that decision, and five years is too long to wait before the integration is complete. Furthermore, even after the Kizer plan is carried out, the Boston facilities will still not come close to the existing degree of consolidation at VA Connecticut. As a result, VISN 1 facilities from Connecticut to Maine continue to suffer during this protracted struggle to bring budget realities to Boston.

I hope that this hearing will be productive. As we discuss budgets, efficiencies and consolidations, I think that it is important that everyone work with the most complete and accurate information available. VISN 1 and the Department can be most helpful in that regard. If VISN 1 or VA officials can produce budget information or some rationale that would ameliorate concerns about the future of VA Connecticut, I hope that they will do so at this hearing or soon afterwards.

The VA Healthcare System and Togus
Senator Olympia J. Snowe
September 25, 1998

Thank you. I would like to thank the Chairman and Representative Allen for this opportunity to share my views before the House Government Reform and Oversight Human Resources Subcommittee on a very important issue: the future of the Department of Veterans Affairs Togus Medical and Regional Office Center and veterans health care system. I would also like to applaud the leadership of this committee in highlighting issues of great importance to Maine veterans.

Before I begin, allow me to welcome the witnesses here today: New England Director Dr. Denis FitzGerald; Dr. Bruce Woolette; Jack Bachman; Neal Williams of the Maine Purple Heart; Dr. Nancy Wilson, VA Performance Management Director; and the other guests.

I would like to share with the Committee the experience of Maine veterans, and reflect on some of the changes taking place in the VA system and how they are effecting Maine.

Earlier this year, veterans asked for the Maine Congressional Delegation's intervention in ensuring that Maine veterans are receiving the highest possible quality health care at Togus and other VA facilities. Specifically, they requested an outside, independent review of quality of care at Togus.

Since that time, the delegation has been tireless in its efforts to leave no stone unturned. First, Senator Collins and I asked the Senate Veterans Affairs Committee to send its staff to Togus -- Maine's only VA hospital.

This visit was an opportunity for the Committee to measure quality of care in the VA system in general. It was also an opportunity for Maine's veterans, hospital staff, and the Maine Congressional Delegation to get an outside perspective on the quality of health care at Togus. The visit included meetings with Togus management and a town hall meeting with veterans -- many of whom expressed strong and legitimate concerns about the level of care at the facility.

More recently, the delegation asked the Department of Veterans

Affairs Inspector General to review quality of care at Togus. And today, the Committee has the opportunity to question VA officials and doctors, and veterans about operations at Togus and the future of this vital hospital.

Mr. Chairman, Maine has a large veterans population, -- over 150,000 -- dispersed throughout a state larger than the rest of New England combined. In fact, one in eight Mainers is a veteran. Togus is the only veterans community hospital in our state to serve this population and vast geographical area.

Togus is vital to the veterans of Maine, with physicians and staff who provide outstanding, compassionate care to Maine's veterans. Sadly, however, the positive aspects of Togus have been obscured in recent years by continuing problems at the hospital.

Of course, some of the problems are not isolated to Togus. The VA is the second largest federal department. It operates one of the largest health care networks in the country, but it has been plagued by charges over the years that it does not operate efficiently and does not provide the services

veterans need.

In recent years, the VA has made a number of changes to address these criticisms, including the move to a network model, encompassing the Veterans Integrated Service Networks (VISNs), and a new funding formula, the Veterans Equitable Resource Allocation (VERA).

Under the VISN system, the VA has established 22 new regional networks to coordinate all of the services provided in those networks. The VA maintains that the VISN model is designed to improve efficiency through consolidation, and increase access by doing more with less.

Meanwhile the new funding formula, VERA, is designed to allocate resources based on population. Under VERA, the VA is shifting resources away from regions with fewer veterans to regions with an increasing veterans population. Each VISN is responsible for allocating resources to the medical centers in its network.

I have no question that these changes were proposed in good faith,

and that the architects of the new system are well-intentioned. However, I believe we have a long way to go before we can say that veterans are receiving the treatment they were promised.

I hear from veterans every day, in meetings, in letters, and over the phone, about how the changes in the VA system are effecting them. And no issue has galvanized the Maine Congressional Delegation more than veterans issues and the future of our veterans hospital, Togus. In fact, the delegation has met more times as a group on Togus and veterans issues than any other single issue.

We hear consistently about scheduling and access problems -- where Togus has managed to reduce waiting times for appointments from literally months down to 30 days (still a long wait) for a new appointment -- and funding, recruitment, travel, and a range of other issues. Many of these concerns stem from, or have been aggravated by the changes taking place in the VA system, while others stem from what I view as an absence of leadership and a resistance to change and communication on the part of some VA officials that I have found quite troubling.

I would like to highlight one issue in particular – recruitment. Recruitment at Togus has been a consistent problem since the VA's restructuring effort began. For example, the Chief of Medicine, Cardiologist, and Pulmonologist positions were left vacant for almost two years before being filled recently. Recruiting efforts for the neurology and psychology departments, and another dentist and hygienist for the dental clinic continue. I believe the VA needs to make filling vacant medical positions a higher priority.

It is these and similar concerns that led me, along with the rest of the Maine Congressional Delegation, to conclude that it was necessary to call for independent verification of quality of care at Togus. This is why we asked the Senate Veterans Affairs Committee to visit the facility in July. And it is why we have since called for the VA Inspector General to conduct an audit of hospital operations at Togus. And it is why I appreciate the Committee holding this hearing today.

I am hopeful that these efforts will result in a clearer picture of where Togus is headed. Most importantly, I expect the IG to offer

recommendations for how to improve quality at Togus and in the system. Long waits for service, declining service options, and understaffing are not acceptable, but this is certainly what is happening in Maine under VERA and the VISN system. We must demand that VA address these problems!

There is another theme that consistently marks the concerns of veterans in Maine and other rural areas too -- namely veterans being forced to travel long distances for health care that is available locally though private sector providers.

I understand that the VA is under tremendous pressure to consolidate and cut costs. However, I disagree with the VA's intention to continue transporting veterans long distances for services. In Maine, some veterans are forced to travel from the northern-most reaches of the state to Boston -- over 400 miles in some cases -- for treatment, often on narrow back roads, and in winter weather.

Last year, the Maine Congressional Delegation and the Governor met with VA officials to discuss the future of Togus. Governor Angus King said it

best when he offered an analogy: he said that forcing veterans to travel from northern Maine to Boston is like asking veterans from Boston to travel to Washington, D.C. to see a doctor.

Well, I checked the map and Governor King wasn't exaggerating. If anything, it was an understatement!

From October-September 1997, Togus sent 641 Maine veterans on this journey. From October-May on this year, Togus had already sent 604 Maine veterans to Boston. Through June of this year, Togus referred 182 veterans to Boston for MRI treatment and 158 for necrology service. However, Togus has committed to providing neurology service at Togus, and has entered into contracts with local MRI providers for MRIs. I hope that this is the beginning of a trend in the VA in rural areas. These numbers should come down over time with local contacting. I believe these number must come down!

We need to take into account the unique geographical challenges facing rural veterans and expand options in rural areas for veterans to

receive quality care close to home. That is why I offered and won Senate approval of an amendment designed to help veterans receive medical care as close to home as possible, and minimize the amount of travel required by veterans for care. The measure passed unanimously and was included in the fiscal year 1999 VA-HUD spending bill.

The provision -- which was cosponsored by Senator Collins -- expresses the sense of the Senate that the VA should aim to serve all veterans at health facilities as close to their homes as possible and minimize travel distances when services are not available locally.

The measure also requires a report evaluating the potential cost and impact on the VA health system of assuring that specialty care is available locally. The VA should make a priority of serving all veterans equally, and this amendment will require the VA to study this issue seriously. It is an important first step, but more needs to be done.

The bottom line is that Togus and other medical centers around the country are increasingly strained. I am concerned that we are rapidly

reaching the limits of doing more with less in the VA health care system, particularly at hospitals on the losing end of VERA. In VISN I, which includes Maine, the Network Director, Dr. Denis FitzGerald, is now talking about further across the board cuts of up to five percent for FY99.

In fact, he has instructed all center directors in the New England network to prepare a contingency budget based on an across-the-board cut of five percent. Frankly, this kind of reduction will devastate Togus, possibly forcing drastic changes in the range of service the hospital is able to provide.

I believe that funding for each medical center must be allocated in a fair and equitable manner throughout the VA system -- not just between networks but between centers within networks as well. These allocations within networks should reflect population, just as VERA does, and other important factors, like geography.

The VA has told us that there will be no further reduction in services in Maine, and that an increase in efficiency would offset any future funding

reductions. I am concerned that we have already reached the limits of cost-savings through consolidation of operations and greater efficiencies. Togus currently provides services almost exclusively to mandatory (Category A) veterans. The bottom line is, past cuts have already impacted services – future cuts will likely be no different.

I believe that a fair allocation of VA resources must take into account the regional impact on all subregions within a regional network. To this end, I would call the Committee's attention to a recent GAO study, released last month, which reported on access to the VA system, VA oversight and data collection efforts, and the formulas the separate VISNs use to determine how they will allocate resources each year to the medical centers in their network.

The GAO found that while the VA has increased the number of veterans being served, the VISNs reviewed, and I quote, "used no specific criteria for allocating their resources..."

Furthermore, "VA headquarters neither provides criteria for VISNs to

use to equitably allocate resources nor reviews the allocations for equity." The GAO concludes that the VA "has done little to ensure that the networks fulfill VERA's promise as they allocate resources to their facilities."

I find this lack of oversight of allocations within VISNs particularly troubling, because my experience with Togus suggests that the decline in the number of veterans in New England as a whole has not been replicated in Maine as of yet. Indeed, in Maine, we have actually seen an increase in the number of veterans being served in recent years. In FY94, Togus served 15, 939 veterans. The number of veterans served in Maine has increased each year, and is projected to reach roughly 17,000 this year.

We need to ensure that in regions where shifts in population are not uniform throughout the region – i.e., where some subregions are seeing a significant outflux of veterans while others are evening out or even seeing an increase in veterans population and number of veterans being served – that the allocations reflect population and geography within the VISN.

In closing, I would simply suggest that in order to meet new demands,

the VA, and the New England Region -- and Togus -- must adapt to advances in health care delivery and become more responsive to the changing needs of veterans. This means that the VA and the New England VISN Director must give Togus the tools it needs to serve Maine veterans.

I have nothing but the utmost respect for the men and women who have served in our armed forces. I strongly believe that they should be assured of receiving high quality health care from the VA. We know that the VA is facing challenging times, but the VA must recognize that our veterans are facing serious challenges in accessing the services they were promised, and are concluding that the government they served with honor is reneging on those promises.

Veterans have already fought their share of battles -- these men and women who sacrificed in war so that others could live in peace shouldn't have to fight again for the benefits and respect they have earned. Mr. Chairman, I would once again like to thank you for your leadership and for this opportunity to testify before this Committee.

I will continue to carefully monitor quality of care at Togus, and I appreciate the support of this Committee in helping make further improvements at Togus possible.

Thank you.

Testimony of Senator Susan M. Collins
U.S. House Government Reform and Oversight Committee
Subcommittee on Human Resources
Hearing on the Impact of VA Restructuring on
Health Care Quality for Veterans
September 25, 1998

Mr. Chairman and Members of the Subcommittee, thank you for taking the time to hold this hearing in order to examine the impact of VA restructuring on health care quality for veterans. I am pleased to know that a significant portion of this hearing will focus on the quality of care at Maine's only VA hospital, the Veterans Administration Medical and Regional Office Center (VAMROC) at Togus. Quality care for our country's veterans is an issue of significant importance to myself and other members of the Maine congressional delegation, and I would like to take this opportunity to briefly relate our experiences with the Togus facility.

Among the problems plaguing the Togus hospital in recent years have been medical staff reductions and the attrition of administrative staff, numerous critical physician and other staff vacancies, the threat of further

budget cuts that would impair the quality of care, excessive waiting periods for appointments, and the referral of our veterans to Boston for services that should be provided in Maine.

In response to these concerns, a year ago, the Maine delegation met with Governor Angus King, Dr. Denis FitzGerald, Director of the New England VA Health Care Network, and Mr. Jack Sims, the Director of Togus VAMROC, to discuss these and other difficulties facing Togus. As a result of this meeting, the Togus hospital undertook a 120-day reform effort, designed to help correct a number of serious problems at the facility. In October of last year, the delegation also met with then Acting Secretary of Veterans' Affairs Herschel Gober, and received his assurances that the VA would work to address problems in providing veterans with timely care and in reducing the number of burdensome referrals of Maine veterans to VA facilities in the Boston area.

The 120-day reform period at Togus concluded in February 1998, and the delegation was pleased to learn that some important progress was made. Moreover, in a meeting that month with Veterans' Affairs Secretary Togo West, the delegation received his personal assurance that there would be "no retreat" from progress made in improving health care at the Togus hospital. Secretary West also indicated that he understood the unique geographic problems of providing health care in a large rural state such as Maine, and the considerable difficulties that face veterans asked to travel long distances for medical care. Most recently, Togus VAMROC announced that it had reached an agreement with local Maine hospitals for providing Maine veterans with MRI treatments without having to refer them all the way to Boston.

Nevertheless, despite these hopeful signs, the Maine congressional delegation has continued to hear from veterans, veterans' service organizations, and Togus staff members that serious problems remain at the hospital. On July 23, in response to these persistent concerns, the delegation

called for a comprehensive, detailed, and impartial review of hospital operations to be conducted by the Inspector General of the Department of Veterans Affairs. The Office of the Inspector General, which is a fully-independent position appointed as a watchdog over VA services, is best positioned to provide a detailed and expert evaluation of the hospital from an impartial position. The inspection, called a Quality Patient Assurance review (QPA), is expected to take place this fall. The QPA will assess hospital management, patient access, and health care quality issues.

I look forward to learning the results of the QPA in the hope that it will point to some areas that can be improved to ensure Maine's veterans are receiving the quality care they deserve. I am concerned, however, that the on-going complaints about Togus will have a deleterious, long-term effect on the level of trust that veterans have in the facility. Our veterans need to know that they will receive the best care available when they visit a VA facility. To maintain trust in Togus and other VA medical centers, it is crucial that the Veterans Administration take the steps necessary to correct the problems that

exist in the Veterans Health Care System. Our veterans must be confident that the Veterans Administration will not be content to provide them with anything less than first-class health care.

Those of us who care deeply about the quality of care available to our veterans, however, do not need to wait for a QPA report to know that Togus must not be short changed in the budget process if we expect the facility to continue to improve its current level of services. The Togus Center Director has plans underway to prepare a budget to deal with a "worst case scenario" of a five percent reduction in the facility's budget for FY 99. In recent years, Togus has endured significant budget reductions in real terms, and has attempted to absorb these cuts by improving its efficiencies. Maine's veterans must be assured that any additional budget cuts of this nature will not result in a reduction of services at Togus. This would be unacceptable. The VA must take steps to ensure that its resources are divided in a manner that will allow facilities located in rural areas, such as Togus, to continue to provide a full range of services to Maine's veterans.

I will remain closely involved with the Togus situation, and am eager to learn how both the timeliness and quality of the services provided at the Togus facility could be improved. Again, I am very pleased to know that the Subcommittee is reviewing the critical issue of the quality care in our nation's VA network today. We in the Maine congressional delegation know how important these issues are to the people of our State, and I look forward to working in the Congress to improve health care for all of our country's veterans.

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Testimony of Congressman Sam Gejdenson
Submitted to Committee on Government Reform and Oversight
Hearing on VA Health Care Programs
September 25, 1998

Thank you for this opportunity to share my concerns regarding the future of health care for our most deserving veterans. I want to take this opportunity to welcome Linda Schwartz and thank her for her tireless efforts on behalf of veterans across Connecticut. I also want to thank Chairman Shays and Ranking Member Towns for holding this hearing today.

Over the past few years, and despite much apprehension and inconvenience, Connecticut veterans patiently watched a transformation of two independent in-patient based Medical Centers into a single, primarily out-patient, integrated health care system. These veterans believed that their sacrifices and understanding would be compensated through more effective and efficient health care. However, this system and the quality of health care available to our veterans are both in peril. Instead of benefitting from the rewards of greater efficiency, deeper and more drastic cuts to personnel and programs appear to be an inevitable result of the current funding climate.

Although the overall budget freeze has had an impact on resource allocation, two factors have more directly affected Connecticut veterans. The Veterans Integrated Services Network (VISN) has altered the Veterans Healthcare Administration structure and Veterans Equitable Resource Allocation (VERA) has changed the way health care funds are allocated.

Using the success of the VA Healthcare System - Connecticut as an example, expanding the VISN concept holds great promise for eliminating redundant management and trimming duplicative operating costs. However, with this promise brings added concerns, voiced by both veterans and healthcare providers alike, that decisions more appropriately made locally by the director in the field will be passed on to another more distant and less responsive bureaucratic layer in Boston.

Veterans in my state are even more concerned that in an effort to become more efficient, some care or services may be transferred from local facilities to out-of-area facilities.. This change will require veterans and their families to travel greater distances to receive essential services. I am concerned that this outcome will compromise the overall quality of care available to veterans in areas currently served by local facilities. It was not too long ago that our most frail and elderly veterans had to travel into New York merely to get a hearing aid. Our veterans should not have to travel to New York or Boston for services which currently are, and should

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remain, available here.

In addition, since all funds are allocated to the VISN, any inefficient facilities will more directly affect more efficient counterparts. This perverse outcome adversely affects the quality of health care on a systemwide basis. While solutions to improve inefficient Boston-area medical centers have been proposed and implemented, there will be no relief to Connecticut veterans without direct intervention from VA Central Office to increase funds to Connecticut.

Compounding the effects of this dramatic change to the basic structure of the Veterans Healthcare Administration is its distribution of funds. VERA holds the promise of supporting VHA goals by rewarding efficiency in health care for our veterans. Unfortunately in practice, this objective was not evident in the VISN 1 1998 budget. Despite its progress in efficiency, Connecticut suffered a $3M loss from VERA projected allocations.

VA officials state that the actual budget only declined by a small percentage compared to the previous level. However, changes do not reflect need. VERA is intended to encourage reallocation from underutilized patient facilities to outpatient demand. I have been told that the VERA process stops at the VISN Director's desk and is not carried through to the facility. The 1998 VISN 1 budget reduced the VERA projected allocation by approximately $15M for five facilities in order to provide approximately $30M increase for the remaining four facilities. I fail to understand how this allocation "rewards effective and efficient healthcare practices."

Additionally, Medical Care Collections Funds (MCCF), which are earned by facilities treating veterans with third party insurance, are also distributed only to the VISN Director's desk. Again, what incentives are earned by the facility? Understanding that VERA was not fully implemented this fiscal year, it troubles me greatly that more adverse affects will be felt next year.

The entire Connecticut Delegation has been steadfast and unified in its support for quality health care for our veterans. Recently, we met with Undersecretary Kizer to express our serious concerns about funding cuts which are perceived as getting critically close to the bone.

We already have some professionals within VA Healthcare System - Connecticut who have not received a salary increase in nearly four years. How can the VA compete with a private hospital that is offering a hiring bonus of $5,000 in order to recruit ICU nurses?

Recently, an extremely discouraged veteran called my office in desperation. After waiting at the VA Medical Center Pharmacy for approximately two hours, he was told to come back in another hour. His final wait was five and a half hours. While some things might have been done differently, the underlying cause of this unacceptable outcome is a staff shortage. The VA hires pharmacists with at least one year experience for approximately $51,000 while pharmacy chains, such as Stop & Shop and CVS, start graduates without experience at salaries in the mid-sixties. The good news is that a request has been made to resolve this pay inequity. The bad news is that this increase will have to be absorbed into the existing budget with no relief from either the VISN or Central Office.

I have spoken with Dr. Alfonso Batres, Director of the Veteran Readjustment Counseling Service, regarding the shortage of both a Team Leader and Counselor at the Norwich Veteran Center. Although a Team Leader has been hired, the counselor position remains unfilled after more than a year and a half. Filling this position is crucial to guaranteeing veterans in southeastern Connecticut will receive the range of services they have earned. RCS itself has had an acting District Director for many years.

Undersecretary Kizer has stated that the VA should be in the business of delivering healthcare, not managing hospitals. To this end, during the past year we have dedicated two new ambulatory care centers -- one at the Newington Campus and one at the West Haven Campus. Our veterans and delegation fought hard to bring these clinics to fruition. They need to be fully staffed with the best possible providers.

I have no doubt that I would not be here were it not for the veterans of this nation who liberated Europe from the Nazis. I greatly appreciate their sacrifices and firmly believe that our veterans deserve exactly what they gave us -- the best. We need to fully fund the Veterans Healthcare System in Connecticut.

Thank you Mr. Chairman.

STATEMENT OF THE HON. ROSA L. DeLAURO
GOVERNMENT REFORM AND OVERSIGHT SUBCOMMITTEE
ON HUMAN RESOURCES
FRIDAY, SEPTEMBER 25, 1998

Good morning. I would like to thank Chairman Shays, Ranking Member Towns, and members of the subcommittee for inviting me to join you today.

As the daughter of a veteran, I also want to thank the subcommittee for holding this hearing to address our veterans' concerns about the quality of care that they have received since the VA's reorganization of its health services.

Our nation owes our veterans a tremendous debt. These courageous men and women set their own lives aside and came to the defense of their country, whether in World War I, World War II, Korea, Vietnam, or the Gulf War. It was their dedication that ensured the freedom and opportunity that are the cornerstones of our society. In times of peace, we must not take this freedom and opportunity for granted -- that would be a grave mistake.

The VA health services system is one of the most significant means we have of paying back the enormous debt we owe our veterans. VA hospitals have helped these men and women come to terms with and triumph over the painful physical and mental scars of war.

I will not sit before you today and pretend the our VA health services system is perfect. In fact, our VA hospitals, especially in my state of Connecticut, need our help. Our veterans must be guaranteed quality health care. They need to be assured that this care will be affordable. And of course, our veterans need to receive this care in the most efficient way possible.

VERA, the Veterans Equitable Resource Allocation system, has been touted as the means of providing our veterans with equal access to health care and as an incentive to the regional networks throughout this country to manage their workload and operations efficiently. In 1995, our veterans patiently endured the hardships that VA Connecticut went through as the very first division of Veterans Integrated Services Network 1, or VISN 1, to integrate its facilities to increase outpatient care and efficiency -- the very goals that VERA aims to accomplish nationwide.

I find it troubling that the VA did not integrate the four medical centers in Boston at the same rate as the Connecticut facilities to ensure that limited funds are put to the most effective use. For three years, VA Connecticut subsidized the inefficiencies of the Boston area -- draining essential resources from Connecticut facilities. Last year alone, VA Connecticut had a shortfall of approximately $2 million. At the same time, VA Connecticut increased the number of veterans it served -- from 29,903 in 1995 to 31,963 in 1997 -- while the number of patients served by Boston actually dropped slightly.

In June of this year, the VA took a step in the right direction towards improving the quality and efficiency of health care for all of New England's veterans when it approved the consolidation of inpatient services in Boston at the West Roxbury campus. It is essential that the VA take the next step and ensure that this consolidation results in a more equal allocation of resources within VISN 1.

In July, Congressman Shays and the rest of the Connecticut delegation joined me to send letters to Secretary West and Dr. FitzGerald expressing our deep concerns about this issue. We also raised this issue at a meeting at the VA Connecticut West Haven campus in my district. Our concerns have not been put to rest.

All veterans must receive the same high level of care that they sacrificed so much for. If we truly want to achieve this goal, let's do it. Let's take steps towards a more equal distribution of resources within the New England network. I look forward to working with the VA on this important issue, but we must start now to protect the health and well-being of our veterans.

Congress of the United States

Washington, DC 20515

July 8, 1998

Dr. Denis J. FitzGerald, M.D., M.H.A.
Network Director, VISN 1
VA New England Healthcare System
Network Office, Building 61
200 Springs Road
Bedford, Massachusetts 01730

Dear Dr. Fitzgerald:

We are writing to recognize the Department of Veterans Affairs on its recent step in the right direction to improve efficiency and quality in the VA New England Healthcare System -- the approval of consolidation of inpatient services in Boston at the West Roxbury VA Medical Center campus. We look forward to working with you to ensure that the consolidation is efficient and effective. However, we also must emphasize the necessity of ensuring that it results in a more equal allocation of resources within the Veterans Integrated Services Network 1 (VISN 1).

As you know, Veterans Equitable Recourse Allocation (VERA) has been touted as a means of providing equal access to veterans' health care services and an incentive to the regional networks to manage workload and operations efficiently. Our veterans were patient while VA Connecticut (VA CT) went through the hardship of being the first in VISN 1 to integrate its health facilities and move towards increased outpatient care and efficiency -- the very health care goals that VERA aims to accomplish throughout the nation.

The four medical centers in the Boston area also were supposed to integrate at a similar rate as VA CT, but did not do so until now. As a result, VA CT efficiencies have been supporting inefficiencies in the Boston area, draining essential resources from VA CT. Last year, due to inflation, and mandated and contractual salary increases, VA CT had a shortfall of approximately $2 million.

Now that health services in Boston are beginning to move towards consolidation, we look forward to a more equal distribution of resources within the network. Proposals to more effectively reallocate these resources within VISN 1 must be among the many issues addressed as VISN 1 begins the Boston integration. We look forward to a prompt response on VISN 1 plans to redistribute its funds among its facilities. Please also be pro-active in keeping us informed on future budgetary actions.

Sincerely,

CHRISTOPHER J. DODD
U.S. Senator

JOSEPH L. LIEBERMAN
U.S. Senator

ROSA L. DeLAURO
Member of Congress

BARBARA B. KENNELLY
Member of Congress

SAM GEJDENSON
Member of Congress

CHRISTOPHER SHAYS
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JAMES H. MALONEY
Member of Congress

NANCY L. JOHNSON
Member of Congress

cc: Secretary Togo West

Testimony

Submitted for the Record to

Subcommittee on Human Resources

Committee on Government Oversight

United States House of Representatives

Concerning the Health of the VA-Connecticut Health Care System

By

Yale University School of Medicine

September 25, 1998

Mr. Chairman and distinguished members of the subcommittee:

We are pleased to have the opportunity to submit written testimony on the state of the veterans' health care system in Connecticut. We commend the members of the Subcommittee for reviewing the status of this important safety net for veterans in southern New England.

VA-Connecticut has an outstanding record of patient care, and is a remarkable resource for the 350,000 veterans in Connecticut and adjoining states. The hub of VA-Connecticut is the West Haven Medical Center, a referral center for acute and chronic care in medicine, surgery, psychiatry, and substance abuse. The Newington campus is a principal provider of ambulatory care, and VA-Connecticut also operates satellite ambulatory clinics in Groton, Stamford, and Waterbury. VA-Connecticut has proven to be an important safety net for veterans, for about one-third of eligible veterans in New England use the VA as a source of medical care.

The Yale University School of Medicine is a true partner of the VA-Connecticut system, having had a close affiliation with the West Haven Medical Center, and now VA-Connecticut, for over 40 years. The School of Medicine and VA-Connecticut have formed close links through the years, and many of the VA physicians hold faculty titles and are engaged in research and teaching that enhances the quality of care for veterans. Because of this collaboration VA-Connecticut has nationally recognized clinical and research programs in schizophrenia, alcoholism and post-traumatic stress disorder. The West Haven Medical Center also houses the VA/Yale Center for Neuroscience and Nerve Regeneration, the Eastern Blind Rehabilitation Center, the National Virology Reference Laboratory, and state-of-the-art imaging facilities. In addition, women's health is a focus for the West Haven as well as the Newington campuses. These programs and centers of clinical excellence are continually making new discoveries in the underlying causes of disease. Through our training programs, these new research discoveries are rapidly transformed into various methods for improving the quality of care for Connecticut veterans.

The VA deserves praise for the fundamental changes it is making in the veterans' health care delivery system, both nationally and in Connecticut. The creation of the VA-Connecticut system itself created a higher degree of integration between West Haven and Newington, and permitted VA-Connecticut to streamline services and achieve economies of scale. The VA is also moving in the right direction by placing a greater emphasis on ambulatory care at Newington and West Haven.

Consistent with its emphasis on ambulatory care, the VA has made significant capital investments in VA-Connecticut in ambulatory care facilities, and we are pleased to note the recent dedication of state-of-the-art ambulatory care facilities at the West Haven Campus. The VA is also constructing ambulatory care facilities for the Newington Campus that are expected to house a "Center of Excellence" in ambulatory care.

These physical improvements are accompanied by significant changes in the management structure of the veterans' health care system. The Department of Veterans Affairs has chosen to delegate many decisions to regional networks, or Veterans' Integrated Service Networks (VISNs), and is encouraging them to borrow business practices from the private sector. The Department is also implementing new resource allocation methods that set regional budgets on the basis of patient volume within a region. These policies may not be perfect, but they nonetheless represent a significant and bold step forward in the management of resources available for veterans' health care.

There are, however, troubling signs on the horizon. It is widely assumed that total spending on the veterans' health care system will be more or less flat for the foreseeable future; while we appreciate the importance of fiscal discipline, it is clear that it will be progressively harder to provide the highest standard of care under such constraints, especially for a veterans' population that is aging, that tends to be lower income and may lack any other regular source of care.

In allocating this increasingly limited pool of resources, the VA's new resource allocation method, the Veterans Equitable Resource Allocation (VERA) system, would have the further impact of shifting resources from northeastern states to southern and southwestern regions. This redirection of resources may unfortunately be yet another manifestation of Connecticut's status as a "donor state."

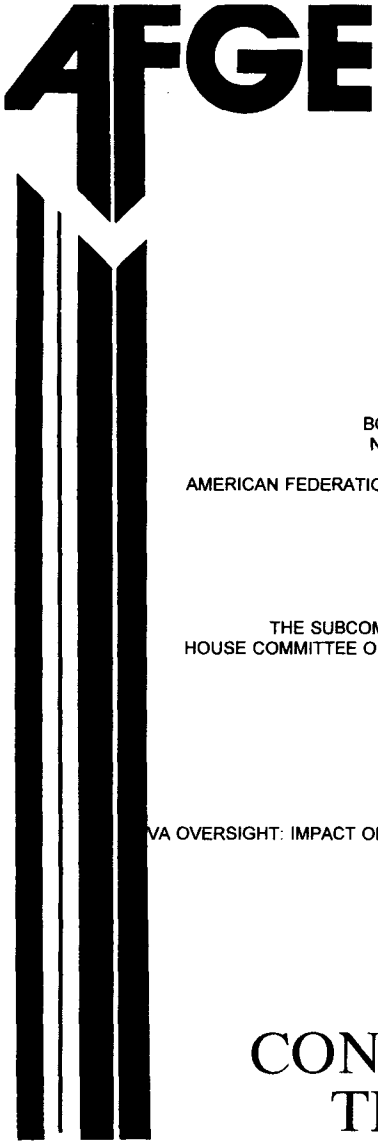
Nor is it clear that Connecticut's veterans have received their fair share within VISN 1, which covers Connecticut, Rhode Island, Massachusetts, New Hampshire, Vermont, and Maine. In fiscal year 1997, when the VERA methodology had not been fully implemented, the budget for VISN 1 was greater than the amount that VERA would have predicted, while VA-Connecticut received less than of the amount that the VERA system would have allocated. The allocation to VA-Connecticut remains below the target set by the VERA system, and the allocation has been declining. This is occurring in spite of a specific allocation of funds for research that is a part of the VERA model. These funds were distributed to the VISN because of the peer-reviewed research projects awarded to our faculty in national competition and funded by the VA Central Office.

Temporary reductions of funding of this magnitude can be absorbed with minimal impact on patient care, but it is not clear how relatively permanent reductions of this size can be accommodated without having a material impact on the scope or quality of services offered to veterans in Connecticut.

In recent years the VA has considered closing certain tertiary care services in VA-Connecticut, and there may still be plans to close surgery or other services at medical facilities within VA-Connecticut. Clearly, Connecticut's veterans would be best served by continuing to obtain high quality care within a reasonable distance of their homes, instead of being required to travel to Boston for care.

These trends are at odds with the tradition of providing high quality care within VA-Connecticut, and they do not bode well for the integrity of the safety net protecting Connecticut's veterans. We believe the VA is doing an excellent job – it faces significant challenges in managing increasingly limited resources, in accommodating dramatic shifts in patient care, and in meeting the changing needs of an aging population of veterans that also expects attention to women's health and other emerging areas of medical practice. We also credit the VA for giving greater authority for decision-making to the regional networks, and for modernizing its financial and management systems. Yet we have serious reservations about whether the veterans' health care system in Connecticut will be able to sustain its standards of quality and the scope of its services, including education and research under the current funding climate. Such an environment - coupled with the implementation of the service line model that, to date, takes little account of the research and education missions of the VA – has begun to raise some very real questions about the nature of our academic affiliation with the VA, a relationship that we have always regarded as among most valued partnerships.

Thank you for providing this opportunity to present our views about the veterans' health system in Connecticut.



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STATEMENT BY

BOBBY L. HARNAGE, SR.
NATIONAL PRESIDENT

AMERICAN FEDERATION OF GOVERNMENT EMPLOYEES, AFL-CIO

BEFORE

THE SUBCOMMITTEE ON HUMAN RESOURCES
HOUSE COMMITTEE ON GOVERNMENT REFORM AND OVERSIGHT

REGARDING

VA OVERSIGHT: IMPACT OF RESTRUCTURING ON HEALTH CARE QUALITY

SEPTEMBER 25, 1998

CONGRESSIONAL TESTIMONY

Mr. Chairman, Representative Towns, and distinguished Committee members, my name is Bobby L. Harnage. I am President of the American Federation of Government Employees, AFL-CIO (AFGE). As the largest federal employees union, AFGE represents over 600,000 federal employees, including approximately 120,000 nurses and other workers in the Department of Veterans' Affairs (VA).

Thank you for the opportunity to testify on behalf of our members who are directly involved in patient care at VA medical facilities in the Veterans Integrated Service Network No.1. These dedicated women and men have a long history of working to improve the quality of patient care in the largest Federal medical care delivery system.

Nurses are Key to Keeping VA's Promise to Veterans of Quality Health Care.

It is the nurses, the aides, the doctors, the medical technicians, the laboratory and pharmacy employees, and the food service workers who make sure veterans receive not only excellent care but are treated with respect and compassion. Ultimately it is not the pieces of paper -- the 30-20-10 plans, or the Prescription for Change or the proposed VISN service lines -- that assure quality health care. (In fact, the implementation of these plans may jeopardize the quality of care.) Instead, it is the surgical nurse who advocates for a patient undergoing surgery, or the nurse who alerts a doctor that a patient needs different medication, or a nurse whose simple but constant attention provides a patient with the healing touch that improves his prognosis, who keep the VA's promise of quality health care to veterans. Caregivers -- not managed-care efficiency experts or cost-cutters -- keep the Veterans Health Administration focused on its mission.

The Retention of High Caliber Nurses is Vital to Sustaining and Improving the Quality of VA's Delivery of Health Care to Veterans.

Because nurses carry out the bulk of medical care at hospitals, it is essential that VA retain nursing staff of the highest caliber. Congress enacted the 1990 Nurses' Pay Act to address nurse staffing shortages at the VA because unquestionably staffing shortages have a negative impact on the delivery of health care. At that time Congress gave each VA medical facility director the authority and discretion to adjust pay levels for VA nurses. Under this alternative pay system, VA Registered Nurses do not receive the annual pay raise that General Schedule (GS) federal employees receive.

The purpose of the alternative pay system was to enable VA medical directors to act quickly and effectively to prevent nurse pay problems so that each VA medical facility could compete for and retain the highest caliber of nursing staff. Directors were to use their broad discretion to fairly compensate the women and men who nurse our nation's ill, disabled, elderly and healing veterans. VA medical facility directors were to have broad control over the salaries of this one group of VA employees under their supervision.

Problems with VA Nurse Pay System -- no raise, low wage limbo.

There is mounting evidence that VA facility directors have manipulated and abused this broad discretion to deny nurses any pay increase or to raise nurses' pay by a paltry amount.

Using VA supplied data, AFGE prepared a chart of the percentage of VA medical facilities which gave nurses a pay raise of one percent or less for 1996 through 1998.

(The chart appears at Appendix A and the raw data from 157 VA medical facilities is in Appendix B.)

According to VA data, in 1996 nearly fifty percent of the medical directors either gave their Nurse Level I and II employees no pay raise, a cut in pay, or an absurdly low pay raise of less than one percent. For example, forty percent of the directors gave Nurse Level I no pay raise. Nurse Level II staff also fared poorly. Thirty-six percent of the directors denied those employees a pay raise. Some directors even reduced nurses' pay. For example, the VA medical facility directors in Columbus, Ohio, Chillecothe, Ohio, Denver, Colorado, Fayetteville, North Carolina, Indianapolis, Indiana, and Iowa City, Iowa cut nurses pay in 1996 in varying amounts, ranging from a reduction of 0.7 percent to a reduction of 4.6 percent.

In VISN 1, the directors at the VA facilities in Bedford, Boston, Brockton, Northhampton, Newington, West Haven, Togus and West Roxbury gave their Nurse Level I and II employees no raise in 1996.

A number of directors gave nurses a pay raise in 1996 but made it so low as to be pointless. For example, the Fargo facility director gave the Nurse Level I staff a one-tenth of one percent (0.1 percent) pay increase and the Marion, Illinois director gave Nurse Level II staff a half of a percent increase (0.5 percent). In all, approximately 10 percent of the directors gave a 1996 pay increase that ranged from 0.1 percent to one percent.

Mr. Chairman, in 1996 these same VA medical facility directors took home a 2.3 percent pay increase, plus locality pay, plus bonuses. Indeed, Dr. Kenneth Kizer, the

VA Under Secretary for Health, handed out a of third of a million dollars ($336,000) in bonuses to senior executives in the field.

In 1997, nationwide the numbers look worse. Roughly half of the VA medical directors either gave Nurse Level I and II staff no raise, a low raise or a pay cut. The bulk gave no raise; approximately forty-five percent gave Nurse Level I staff no raise and forty-one percent gave the more experienced Level II staff no raise.

In 1997 in VISN I, the directors at the VA facilities in Bedford, Boston, Brockton, Northhampton, Newington, West Haven, Togus and West Roxbury gave their Nurse Level I and II employees no raise in 1996.

As in 1996, a few directors even decreased nurses pay. For example, the Jamaica Plains director cut Nurse I and II employees pay by almost $1,000. The Louisville director cut Nurse II pay by 2.6 percent and the Biloxi director cut Nurse II pay by 1.1 percent.

Mr. Chairman, in 1997 these same VA medical facility directors automatically received a 2.3 percent pay increase, plus locality pay. Directors -- unlike the nurses they supervise -- have received the GS annual pay adjustment as a matter of course. On top of these increases, some even pocketed pay bonuses from Dr. Kenneth Kizer. In VISN 1, three senior VA executives received bonus awards of $7,000. Roughly half a million dollars ($516,000) were given to directors across all 22 VISNs.

Thanks to persistent Congressional inquiries into this problem, in 1998, the numbers began to change. Suddenly, the directors in VISN 1 "saw the light" and finally gave their entry level nurses a raises. But without your continued oversight and action,

Mr. Chairman, I fear that VA directors will go back to their past practices both to the detriment of VA nurses and veterans under the VA's care.

While overall in 1998 more directors gave their nursing staff a pay raise, let's be clear the bulk of these raises fall short of the increases received by other federal employees, including the VA medical facility directors.

The VA calculated that in 1998 the average national pay raise for nurses was 2.2 percent. (See last page of Appendix B.) This average is lower than the 2.3 percent pay increase *plus* locality pay received by GS employees. Nearly three-quarters (73 percent) of the directors gave Nurse Level I and II staff less than a 2.9 percent increase -- the total pay adjustment plus locality pay that was given to GS employees who do not work in named locality areas.

Even in 1998, roughly twenty percent of all the VA the directors gave their Nurse Level I and II staff no increase at all. The Nurse I and II employees at West Haven and Newington received no pay raises and 10 of the 13 VISN 1 directors froze the salaries of Nurse Level II employees.

As currently implemented, the VA nurse pay system allows VA medical facility directors to exploit the dedication of VA nurses.

Mr. Chairman, I cannot believe Congress intended for the VA to implement this alternative pay system in this manner. Is this the approach you want VA facilities to take to increase the quality of care to veterans by preventing nurses' pay problems, staffing shortages and rewarding dedicated nurses?

And, Mr. Chairman, VA nurses are very dedicated professionals. I'm sure you

remember the government shutdown a few years ago. VA nurses and other dedicated direct care staff showed up for work every day of that shutdown, even when it was unclear whether they would receive a paycheck.

Veterans and the Veterans Health Administration can and do count on the dedication, compassion and professionalism of the VA's nursing staff. It's time for the VA nurses to be able to count on *at least* the annual pay adjustments provided to General Schedule (GS) federal employees.

How VA Medical Facility Directors Abuse their Authority In Implementing the Law.

VA nurses are in this no raise, low-wage limbo because VA medical facilities directors are not implementing the law appropriately.

Under the Nurses' Locality Pay Act medical facility directors have the discretion to make locality pay adjustments based upon a local pay survey. According to a 1993 General Accounting Office study (GAO-T-HRD-92-35), few, if any, VA medical facilities conducted nurses' locality pay surveys in a manner consistent with Bureau of Labor Statistics survey methods.

Typically, the surveys failed to use a well-defined system to match the job duties and responsibilities of the nurses whose salaries are being compared, failed to conduct personal interviews to collect survey data and verify the data obtained, and the VA failed to validate surveys done by most centers. That means that the VA's salary data frequently compared the pay of VA nurses with non-VA nurses who had fewer responsibilities and inferior technical skills. Thus, the basis for determining whether VA

nurses' salaries are competitive within the local market is likely inaccurate.

The VA has taken some steps to address the deficiencies in the surveys, but the failure to gather accurate and complete salary data continues to be an ongoing problem in VA's implementation of the law.

The problem of invalid job matches is recurring and particularly difficult. For example, in many private sector hospitals a nurse does not perform respiratory therapy. A special medical technician has those duties. At VA facilities, nurses routinely are required to perform respiratory therapy. VA medical facility directors do not have the expertise (or perhaps the inclination) to perform the complex statistical adjustment to create an accurate salary proxy that reflects what non-VA facilities would pay a nurse who has all of the various duties and requirements routinely expected of VA nurses.

Because VA medical facility directors routinely rely on survey data that fails to compare the pay of VA nurses with non-VA nurses who have equivalent responsibilities and skills, VA nurses have suffered pay freezes.

This spring, VA Secretary Togo West admitted to Congress that a "major concern with the current system is the validity of the data obtained through the survey process. Many community establishments are reluctant to participate in VA salary surveys due to fear of anti-trust (price fixing) allegations. Oftentimes the data provided may not accurately represent the salaries actually offered to new hires." (Written response as part of testimony for March 17, 1998 testimony before the House Appropriations VA-HUD Subcommittee.)

VA medical facility directors abuse their discretion and exacerbate the problems

of poorly conducted surveys when they knowingly rely on faulty and deficient data to justify a paltry pay raise or to deny hardworking and dedicated nurses any salary increase. Some directors maintain that if they obtain any survey data -- no matter how little or how inaccurate -- that they must base salary adjustments on the unreliable salary information.

For example, the director of the Amarillo, Texas, VA medical center decided in 1996 not to increase the pay for registered nurses in that facility even though the director knew that the survey results were highly questionable. In the director's justification memorandum, it was readily acknowledged that the "most recent survey indicates that some area facilities were less than forthright with our data collectors during previous surveys" and "[t]he practice of telling VA data collectors only what they want them to know calls into question the validity of all such pay surveys." (See Appendix C.)

The director of the New York City VA medical center decided that "stable recruitment/retention and reduced budgets have led us to request that the Title V and Title 38 Special salary rates in effect at this station not receive the national 'cost of living' increase for 1997." This conclusion was reached contrary to the admission that the "[r]esponse to our survey this year was poor. Like last year, we failed to find three job matches . . . and therefore we have no valid survey data." (See Appendix D.)

For 1997, the acting director of the Sepulveda, California, medical facility justified no pay increases for all five grade levels of Nurses at the facility on the basis of a very limited and flawed survey. Of 28 hospitals randomly contacted for the local salary survey (out of a possible 134 hospitals) --only eight participated, for a 71 % nonparticipation rate

within an already limited sample group in the survey. Moreover, the director's rationale for no pay increase conceded that the survey "is not a good representation of our Local Labor Market . . ." (See Appendix E.)

These actions appear contrary to VA policy and the mandates of the law. But on those same justification memoranda, and on others, are the handwritten "o.k. -- no adjustment" from VA administration officials who review the nurse pay adjustments.

This kind of rubber-stamp review of VA medical facility directors' implementation of the law and VA regulations is very troubling. It suggests that VHA administration officials do not take seriously the purpose of the Nurses' Pay Act -- to maintain and improve the quality of health care by increasing pay to prevent pay problems and to prevent staffing shortages.

Last December, after repeated Congressional inquiries, Dr. Kizer reminded VA medical facility directors that they are not forced to use inaccurate or incomplete data. "If survey data is not obtainable, the facility Director may pass on all or part of the amount of the GS adjustment to each nurse grade unless it is determined to be unnecessary to recruit and retain well-qualified employees." (Under Secretary for Health Information Letter: Nurse Locality Pay System Adjustments, IL 10-97-042, December 12, 1997, at paragraph 3.)

One would hope that this would help. But our AFGE members in Louisville -- the nurses who received pay cuts in 1997 and 1998 -- have told us that their Director narrowly interpreted Dr. Kizer's letter. The director claimed he could not pass along the GS pay adjustment because he did obtain "some" data.

Even when a facility's survey data shows that VA nurses are underpaid in comparison to their private sector counterparts, some directors still do not increase nurses' pay because they contend that the facility must *currently* be experiencing recruitment or retention difficulties.

In pay adjustment justification memoranda denying nurses pay increases VA medical facility directors repeat the refrain "no recruitment or retention problems." These are magic words because under VA regulations that simple declaration means a director may deny nurses pay increases, regardless of the survey data.

Under the law it is clear that Congress wanted directors to act *before* a recruitment or retention problem developed. Currently, the VA regulations on the nurses' pay system contain no provisions or definitions as to what constitutes a problem in retention or recruitment. The VA regulations implementing this law are silent as to what indicators a director may legitimately rely upon to determine whether a potential recruitment or retention problem exists. Directors are left to their own discretion and without regulatory guidance VA administration officials simply don't question or review whether VA directors have legitimately used the magic refrain of "no retention or recruitment problems."

VA officials may try to claim that turnover at VA facilities is not high and that is proof that no retention problems are evident. Higher quit rates and recurring or higher vacancy rates may reveal gross difficulties in retention and recruitment. But these indicators reflect current -- not impending -- problems. In addition, statistics on turnover or vacancies rates may be falsely low due to a reduced full-time employee equivalents

(FTEE) ceiling. Moreover, when staffing shortages begin to be a problem, the risk of patient neglect also increases. The VA should issue clear guidelines on the objective factors which constitute an impending staffing shortage, so the problem can be alleviated through an appropriate pay increase.

What Is Prompting VA Medical Facility Directors to Misuse and Exploit their Authority Under the Law?

The Veterans Equity Resource Allocation model, known as VERA, seems to be an underlying force encouraging directors to deny nurses the compensation they deserve. VERA allocates funding to the 22 Veterans Integrated Service Networks (VISNs) based in large part on managed care and management efficiencies.

VERA allocations reward facilities and networks for efficiencies that result in reduced patient care costs. Under the VERA calculations, the incentives to hold down salaries are even stronger for VISNs that have not been as successful in recovering medical care collections from health-care insurers.

While patient care costs might be reduced in a variety of ways, under the VERA formula for "patient care cost" one sure-fire way for a VISN to lower patient care costs is to keep staff salaries stagnant or depressed. Nurses' pay makes up a significant portion of each facility's salary expenditures. And unlike other employees under their supervision, VA medical facility directors can control nurses' pay increases. Indeed, VA medical facility directors have the discretion to cut nurses' salaries. The annual GS increase given to other employees, like pharmacy technicians, doctors, nurses aides and even the medical facility director, are not subject to the discretion of the medical facility

director or VISN director.

VERA may create an unintended, but nonetheless perverse, incentive for VA medical facility directors to deny nurses the annual pay increases they are due.

Given the calculus of VERA and the repeated difficulty directors have in obtaining adequate and accurate salary data from non-VA facilities, VA medical facility directors have no incentive to either conduct valid surveys or use their discretion to pass on the GS annual pay increase.

But even a logical explanation does not exonerate balancing budgets on the backs of nurses. It is wrong for VA medical facility directors to exercise their discretion unfairly and inappropriately.

Mr. Chairmen, AFGE believes that VA nurses should be viewed as a valuable resource, rather than as an easy target for so-called "efficiency." Denying VA nurses any pay increase or giving them de minimis raises is no way to treat the very staff who are key to keeping VA's promise of quality health care to veterans.

What Can Be Done to Remedy this Problem Which Places Patient Care at Risk?

It is clear from the actions of VA officials and VA medical facility directors that when Representatives and Senators are scrutinizing how they implement the law nurses benefit. We strongly urge you to continue your critical oversight activities because they do make a difference in the lives of VA nurses and their patients.

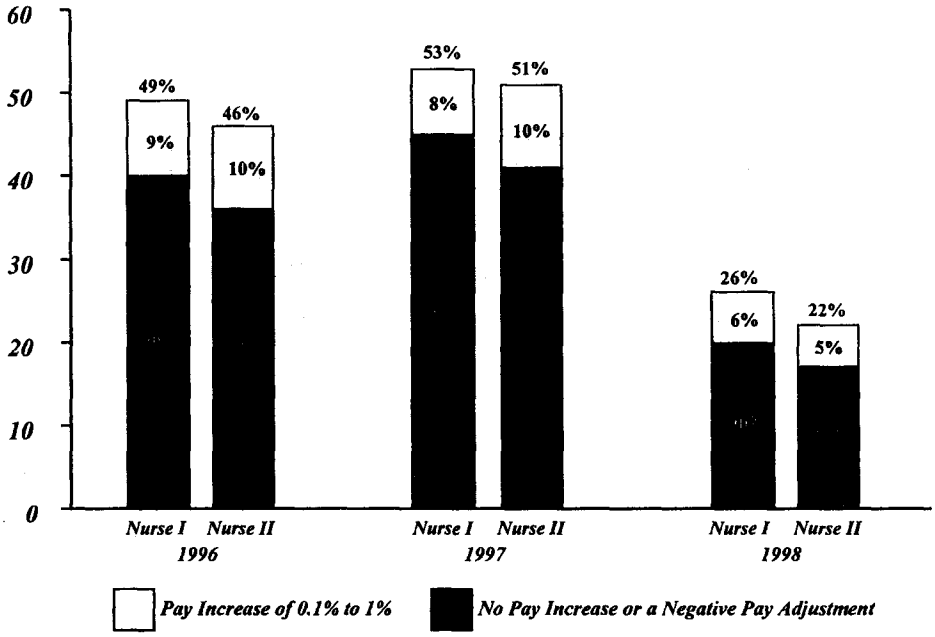
And yet, when this year alone nearly three-quarters of the facility directors failed to give nurses at least the equivalent of the annual GS pay adjustment given to other VA employees at their locality, it is clear that even vigilant oversight is not enough.

AFGE urges you to take action to ensure that in FY 1999 and FY 2000 nurses at all VA medical facilities receive -- at a minimum -- the pay adjustment authorized to GS employees. During this two-year period the VA could propose the necessary legislation to fix this troubled alternative pay system. We understand that the VA has already procured a contractor to recommend necessary regulatory and statutory changes to address some of these problems. While I can't comment on the report and recommendations until we have an opportunity to review and analyze the proposed changes, I think it would be very useful if this committee held a hearing specifically to examine possible remedies to this flawed pay system.

That concludes my remarks. I will be happy to answer any questions.

Appendix A

Percentage of VA Facilities that Awarded Nurses a Pay Increase of 1% or Less (1996-1998)



Appendix B

Raw Data of Nurse Locality Pay Adjustments for 157 VA Medical Facilities for 1996-1998

Source: VHA Office of the Chief Administrative Officer Management and Support Office

Nurse Locality Pay Adjustments

FACILITY	% CHANGE BY GRADE - 1/98			% CHANGE BY GRADE - 1/97			% CHANGE BY GRADE - 1/96		
	I	II	III	I	II	III	I	II	III
ALBANY	0.5	0.5	0.5	1.7	1.0	1.0	2.9	2.4	2.3
ALBUQUERQUE	0.0	0.0	0.0	0.9	2.3	2.3	2.0	0.7	1.6
ALEXANDRIA	2.1	2.1	1.4	1.0	0.0	0.0	0.0	0.0	0.0
ALTOONA	4.0	2.3	2.3	2.3	2.3	2.3	2.0	2.0	2.0
AMARILLO	2.0	2.0	2.0	0.0	2.3	2.3	0.0	0.0	0.0
AMERICAN LAKE	4.5	1.6	3.1	0.0	0.0	1.9	0.0	0.0	0.0
ANCHORAGE	2.3	2.3	2.3	2.3	2.3	2.3	1.0	1.0	2.0
ASHEVILLE	4.2	6.1	2.3	2.3	0.0	2.3	0.0	1.3	2.2
ATLANTA	2.3	2.3	2.3	2.0	2.0	2.0	2.0	2.0	2.0
AUGUSTA	1.0	1.0	2.2	5.0	3.0	7.9	0.8	0.0	0.0
BALTIMORE	2.5	2.6	2.5	3.0	3.0	1.9	2.0	2.0	3.0
BATAVIA	2.0	3.1	3.0	0.0	0.0	0.0	0.0	0.0	0.0
BATH	2.3	2.3	2.3	2.3	2.3	2.3	2.4	2.4	2.4
BATTLE CREEK	1.3	1.3	0.0	1.6	1.6	0.0	2.0	2.5	2.0
BAY PINES	5.7	2.9	2.9	0.0	0.4	3.0	1.0	1.0	1.0
BECKLEY	1.7	2.9	2.9	3.0	3.0	3.0	2.4	2.4	2.4
BEDFORD	6.6	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
BIG SPRING	1.5	1.5	3.0	2.0	2.0	2.0	0.0	0.0	0.0
BILOXI	3.2	2.3	2.3	0.0	-1.1	0.0	1.5	1.4	3.4
BIRMINGHAM	1.0	1.0	1.0	2.2	0.0	0.0	0.0	0.0	0.0
BOISE	9.0	0.1	2.9	2.8	1.0	1.0	2.0	1.0	1.5
BONHAM	2.3	5.0	2.3	1.3	1.2	1.3	0.0	0.0	0.0
BOSTON	6.6	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
BROCKTON	6.6	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
BRONX	2.3	2.3	2.3	0.0	0.0	0.0	0.0	0.0	0.0
BROOKLYN	2.3	2.3	2.3	0.0	0.0	0.0	0.0	0.0	0.0
BUFFALO	2.0	2.0	2.0	0.0	0.0	0.0	1.0	1.0	1.0
BUTLER	2.3	2.3	2.8	0.0	0.0	0.0	1.0	1.0	1.0
CANDNDAIGUA	0.0	2.3	3.5	0.0	2.6	3.0	0.0	3.0	6.0
CASTLE POINT	2.9	2.6	2.6	0.0	0.0	0.0	0.0	0.0	0.0
CENTRAL TEXAS MC	0.1	7.7	9.1	1.0	0.0	0.0	1.1	0.0	0.0
CHARLESTON	0.8	2.5	5.9	2.9	2.9	2.9	3.2	1.2	2.0
CHEYENNE	1.8	0.5	1.0	0.9	0.7	3.7	2.6	2.0	2.4
CHICAGO	4.0	8.0	7.9	0.0	0.0	0.0	2.0	2.0	2.0
CHILLECOTHE	2.9	2.9	2.9	1.5	0.0	0.0	-0.7	2.4	2.4
CINCINNATI	1.0	2.0	1.0	1.0	2.0	2.5	1.0	0.8	0.5
CLARKSBURG	2.9	2.9	2.9	0.0	0.0	0.0	2.0	2.0	3.0
CLEVELAND	2.3	2.3	2.3	1.5	2.0	-0.4	2.4	2.4	2.4
COATESVILLE	2.7	2.7	2.7	0.0	0.0	0.0	2.0	2.0	2.0
COLUMBIA MO	2.0	2.0	2.0	0.0	0.0	0.0	2.0	2.0	2.0
COLUMBIA SC	2.4	2.4	2.4	2.8	2.8	1.8	0.0	0.0	0.0
COLUMBUS	3.0	3.0	3.0	2.2	2.3	2.3	-2.8	2.5	2.5
CONNECTICUT HCS	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
DALLAS	2.3	5.0	2.3	0.7	2.5	2.5	0.0	2.6	2.6
DANVILLE	-1.7	0.0	0.0	0.9	1.0	-0.4	2.4	2.4	2.4
DAYTON	2.0	2.5	2.0	0.0	1.0	1.0	0.0	1.0	1.0
DENVER	3.6	4.5	3.8	0.0	0.0	0.0	-1.5	-2.7	2.0
DES MOINES	-1.4	2.3	4.2	0.0	0.0	2.3	4.5	3.2	2.0
DETROIT	1.5	1.5	1.5	1.0	1.0	1.0	1.6	2.0	2.0
DUBLIN	2.0	2.7	1.5	2.5	0.9	0.1	2.0	5.1	1.8
DURHAM	2.3	2.3	2.3	0.0	0.0	0.0	0.0	0.0	0.0

Nurse Locality Pay Adjustments

NEW JERSEY HCS	2.3	2.3	2.3	0.0	0.0	0.0	0.0	0.0	0.0
EL PASO	0.0	0.0	0.0	1.1	1.5	1.5	2.0	2.0	1.8
ERIE	1.0	0.8	3.0	2.3	2.3	2.8	1.1	1.5	1.5
FARGO	0.0	2.3	2.3	2.0	2.3	2.3	0.1	2.0	2.0
FAYETTEVILLE AR	2.9	2.9	2.3	0.0	3.0	3.0	4.4	2.0	2.6
FAYETTEVILLE NC	4.4	2.3	2.3	0.0	0.0	0.0	-2.7	1.0	-1.7
FORT HARRISON	1.0	1.0	1.0	3.0	3.0	3.0	2.0	2.0	2.0
FORT HOWARD	2.5	2.6	2.5	3.0	3.0	1.9	0.0	0.0	0.0
FORT LYON	2.6	2.9	2.9	1.9	2.8	3.0	2.4	2.4	2.4
FORT MEADE	2.0	2.0	2.0	3.7	2.9	1.2	3.9	2.9	2.4
FORT WAYNE	6.2	2.3	2.3	0.0	0.0	0.0	0.0	0.0	0.0
FRESNO	0.0	0.0	0.0	0.0	2.3	2.3	2.0	2.0	2.0
GAINESVILLE	3.7	4.8	9.3	3.0	0.4	3.0	2.4	2.4	2.4
GRAND ISLAND	1.5	1.5	1.5	2.0	2.0	2.0	2.0	2.0	2.0
GRAND JUNCTION	0.0	0.0	0.0	2.5	2.5	5.0	0.0	0.0	0.0
HAMPTON	2.3	2.3	2.3	3.0	3.0	3.0	2.0	2.0	2.0
HINES	4.0	8.0	7.9	0.0	0.0	0.0	2.0	2.0	2.0
HONOLULU	0.0	0.0	0.0	2.3	2.3	2.3	2.0	2.0	2.0
HOT SPRINGS	2.0	2.0	2.0	3.7	2.9	1.2	0.2	2.6	2.2
HOUSTON	0.0	6.4	1.7	1.7	3.0	2.0	0.0	3.0	0.0
HUNTINGTON	2.3	2.3	2.3	2.3	2.3	2.3	2.0	2.0	2.0
INDIANAPOLIS	2.4	3.0	4.0	0.0	6.8	-3.2	0.0	-4.6	0.0
IOWA CITY	1.0	1.5	2.3	0.0	0.0	0.0	-0.3	0.0	0.0
IRON MOUNTAIN	2.3	2.3	2.3	0.0	0.0	-3.5	-0.2	2.4	2.8
JACKSON	1.2	2.6	1.9	1.7	2.2	3.0	2.2	2.4	2.4
KANSAS CITY	2.0	0.8	1.5	1.1	3.0	0.0	0.7	0.0	0.0
KERRVILLE	1.6	2.9	2.9	3.0	3.0	3.0	0.0	0.0	0.0
LAKE CITY	4.2	4.8	9.3	3.0	1.9	4.9	2.4	2.4	2.4
LAS VEGAS	0.0	2.9	2.9	3.0	3.0	3.0	3.0	3.0	3.0
LEAVENWORTH	2.3	1.0	2.3	0.0	2.8	0.6	0.0	0.0	0.0
LEBANON	1.6	1.7	1.6	1.0	1.0	1.0	0.0	0.0	0.0
LEXINGTON	2.9	2.9	2.9	1.0	1.0	4.3	2.0	2.0	2.0
LINCOLN	1.5	1.5	1.5	1.2	0.9	1.5	0.8	0.9	1.0
LITTLE ROCK	2.3	2.3	2.3	2.4	1.4	0.0	2.0	2.0	2.0
LOMA LINDA	2.3	2.3	2.3	0.0	0.0	0.0	0.0	0.0	0.0
LONG BEACH	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
LOS ANGELES	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
LOUISVILLE	-0.1	-7.7	-1.8	0.9	-2.6	2.8	0.0	0.0	2.5
MADISON	3.9	3.9	3.9	0.0	0.0	0.0	2.9	2.1	2.1
MANCHESTER	2.3	0.0	0.0	0.0	0.0	0.0	2.0	0.0	0.0
MANILA	2.3	2.3	2.3	2.3	2.3	2.3	2.0	2.0	2.0
MARION IL	2.9	2.1	2.3	1.5	1.9	1.6	3.2	0.5	0.5
MARION IN	2.3	2.3	2.3	1.9	2.3	2.3	0.0	0.0	0.0
MARTINSBURG	2.3	2.3	2.3	3.2	3.2	3.2	2.5	2.5	2.5
MEMPHIS	2.8	5.7	4.0	0.0	0.0	0.0	0.8	2.0	0.5
MIAMI	2.3	2.3	2.3	1.2	3.0	2.3	0.0	1.3	0.7
MILES CITY	2.3	0.0	0.0	2.3	7.7	0.0	2.0	2.0	0.0
MILWAUKEE	2.9	2.9	2.3	0.0	0.0	0.0	2.7	2.6	0.3
MINNEAPOLIS	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
MONTGOMERY	2.3	2.3	2.3	1.5	0.9	3.6	0.0	0.0	0.0
MONTROSE	2.9	2.9	2.9	0.0	0.0	0.0	0.0	0.0	0.0
MOUNTAIN HOME	3.6	2.3	3.5	1.3	1.3	1.3	2.0	2.0	2.0
MURFREESBORO	4.6	3.7	3.1	0.0	0.0	0.0	1.8	0.0	0.0

MUSKOGEE	0.0	0.0	0.0	0.0	0.0	0.0	2.0	2.0	2.0
NASHVILLE	4.6	3.7	3.1	0.0	0.0	0.0	1.8	0.0	0.0
NEW ORLEANS	0.0	0.0	0.0	0.0	0.0	0.0	1.3	2.4	2.4
NEW YORK	2.3	2.3	2.3	0.0	0.0	0.0	0.0	0.0	0.0
NORTH CHICAGO	4.0	4.0	4.0	0.0	0.0	0.0	2.0	2.0	2.0
NORTHAMPTON	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
NORTHPORT	2.3	2.3	2.3	0.0	0.0	0.0	0.0	0.0	0.0
OKLAHOMA CITY	2.0	2.0	0.8	2.0	2.0	2.0	0.0	0.0	2.6
OMAHA	0.0	1.5	1.5	0.5	0.5	0.5	0.0	0.0	0.0
PALO ALTO	0.0	0.0	0.0	2.3	2.3	2.3	0.0	0.0	0.0
PHILADELPHIA	2.3	2.3	2.3	0.0	0.0	0.0	2.6	2.6	2.6
PHOENIX	2.3	2.3	2.3	0.0	0.0	0.0	2.5	3.7	1.4
PITTSBURGH	1.0	2.7	2.3	0.0	0.0	0.0	0.0	0.5	0.5
POPLAR BLUFF	2.9	2.3	1.2	0.0	0.0	0.0	1.8	1.6	1.6
PORTLAND	2.3	2.3	2.3	2.3	2.3	2.1	1.5	1.5	1.5
PRESCOTT	0.0	0.0	0.0	0.0	0.0	0.0	2.0	2.0	0.0
PROVIDENCE	2.3	2.3	2.3	0.0	0.0	0.0	2.0	2.0	2.0
RENO	0.0	0.4	0.2	6.4	0.8	2.7	2.4	0.6	2.4
RICHMOND	0.0	0.0	0.0	2.3	2.3	2.3	0.0	0.0	0.0
ROSEBURG	5.0	3.7	3.7	3.0	3.0	3.0	2.4	4.1	4.3
SAGINAW	2.5	5.7	4.0	2.3	2.3	2.3	4.9	3.9	3.6
SALEM	4.0	4.0	4.0	0.8	2.8	2.8	2.5	3.6	5.8
SALISBURY	0.0	1.9	2.0	0.0	1.0	2.8	0.0	1.4	1.4
SALT LAKE CITY	2.9	2.9	3.5	4.6	2.3	2.3	2.0	3.0	3.0
SAN ANTONIO	0.0	2.9	2.9	0.6	3.0	3.0	0.0	2.4	2.4
SAN DIEGO	4.0	6.6	6.6	0.0	0.0	0.0	0.0	0.0	0.0
SAN FRANCISCO	2.3	2.3	2.3	2.3	2.3	2.3	0.0	0.0	0.0
SAN JUAN	2.3	2.3	2.3	2.3	2.3	2.3	2.0	2.0	2.0
SEATTLE	5.7	3.1	3.1	0.0	0.0	1.9	2.0	2.1	2.0
SEPULVEDA	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
SHERIDAN	0.0	1.0	1.0	1.9	1.9	2.0	1.4	1.4	2.0
SHREVEPORT	2.9	2.9	2.9	3.0	3.0	3.0	2.4	2.4	2.4
SIOUX FALLS	0.0	0.0	0.0	2.3	2.3	2.3	2.4	2.4	2.4
SPOKANE	2.3	2.3	2.3	2.4	2.3	2.3	2.0	2.0	2.0
ST. CLOUD	2.9	2.9	1.2	2.0	1.5	1.0	2.4	2.4	1.0
ST. LOUIS	2.0	2.0	2.0	0.0	2.0	2.0	0.0	0.0	0.0
SYRACUSE	2.3	2.3	2.3	1.8	2.0	2.0	2.0	2.4	2.3
TAMPA	2.9	2.9	2.9	0.0	0.4	3.0	1.0	1.0	1.0
TOGUS	2.3	2.3	2.3	0.0	0.0	0.0	0.0	0.0	0.4
TOMAH	4.0	4.0	4.0	0.0	0.0	0.0	0.0	0.0	-1.8
TOPEKA	2.3	2.3	2.3	2.0	2.0	2.0	2.0	2.0	2.0
TUCSON	1.7	2.4	8.5	0.9	0.1	0.0	0.0	0.0	0.0
TUSCALOOSA	1.3	2.3	2.5	0.0	1.0	2.7	2.0	2.0	2.0
VANCHCS	0.0	0.0	0.0	2.3	2.3	2.3	0.0	0.0	0.0
WALLA WALLA	2.9	2.9	2.9	2.3	2.3	2.3	2.0	2.0	2.0
WASHINGTON DC	2.5	2.2	0.9	0.6	2.0	2.0	1.7	2.5	5.0
WEST LOS ANGELES	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
WEST PALM BEACH	2.3	2.3	2.3	0.0	0.0	0.0	0.0	2.0	2.0
WHITE CITY	3.0	3.0	3.0	3.0	3.0	3.0	2.4	2.4	2.4
WHITE RIVER JUNC	2.3	2.3	2.3	0.0	0.0	0.0	2.0	2.0	2.0
WICHITA	2.3	2.3	3.4	-8.0	0.0	0.0	0.7	0.7	0.7
WILKES-BARRE	1.5	1.5	1.5	0.0	0.0	0.0	1.0	1.0	1.0
WILMINGTON	1.5	1.5	1.5	1.5	1.5	1.5	1.5	1.5	1.5

Nurse Locality Pay Adjustments

AVERAGE BY GRADE	2.1	2.2	2.3	1.1	1.3	1.3	1.1	1.3	1.3
NATIONAL AVERAGE		2.2			1.2			1.2	

Appendix C

nent of
ans Affairs

Memorandum

January 5, 1996

From: Director, Amarillo, TX, VAMC (05)

Subj: Nurse Locality Pay Survey (NLPS)/Schedules

To: Field Support, VACO, (133/052D)

1. Enclosed are survey summaries for Nurse Locality Pay Surveys for Staff Nurses, Amarillo VAMC, N001; Staff Nurses, Clovis, NM, and Lubbock, TX, OPC's, N003; Administrative Nurses, Amarillo VAMC, N004; and Nurse Practitioners, Amarillo VAMC, N005. A survey summary for Certified Nurse Anesthetists (CRNA's), Amarillo VAMC, N002, is not enclosed because the new NLPS software will not print survey summaries when all facilities in the Local Labor Market Area (LLMA) have zero occupational employment. No medical facilities in our LLMA were found to have CRNA's on staff.

2. Medical facilities throughout the Texas Panhandle have been in turmoil during the past year. Family Hospital in Amarillo was surveyed last year. They are no longer in business. Two large medical centers, St. Anthonys and High Plains Baptist, will merge this month. According to local news reports, Northwest Texas Hospital has talked to several prospective buyers. They are now negotiating, and it appears that NWTH may be sold in the Spring. Northwest Texas Hospital eliminated a complete layer of nurse managers within the past year. Some Medical Facilities in Lubbock are no longer paying new hires at the rates paid to employees hired in previous years.

3. Further impacting NLPS in this area is the fact that this most recent survey indicates that some area facilities were less than forthright with our data collectors during previous surveys. According to those giving data, some hospitals have increased salaries for entry level nurses up to an additional $4.50 per hour in the past year. Supposedly, this increase was given at a time when we have had no difficulty recruiting entry level nurses despite much lower salaries. In actuality, those hospitals were paying higher entry rates in the past when we were finding it difficult to hire nurses. When our data collectors mentioned that a much lower entry salary was given last year, they were told that yes, the figure they were given is the minimum published rate; however, they had not hired registered nurses at

CRNA - no adjustment - ok - less than 3 participating establishments

VA FORM 2105 MAR 1989 RN - ok - existing rates do not exceed max.
(& all other schedules)

that low a rate in several years. The practice of telling VA data collectors only what they want them to know calls into question the validity of all such pay surveys.

4. The foregoing considerations and anticipation of continued turmoil within the health care community combined with the fact that we have had no problems recruiting and retaining nurses during the last few months have led me to decide that I will not change Nurse pay schedules at this time. For the time being, we will continue to use the nurse pay schedules established in January 1995.

5. Although some rates are more than five percent above or below community averages, the rates for all grades on all current nurse pay schedules are well within communities' lowest and highest minimum entry rates. This has been a difficult decision to make; however, I feel changes should not be made until nurse salaries in this area are closer to stabilization. I know that nurses will be disappointed in receiving no salary increases, but I feel an upward adjustment at this time could cause a mandatory downward adjustment in the near future.

6. Recruiting for some nurse vacancies is anticipated in the near future. It is my understanding that, when vacancies are difficult to fill, I may use data from this survey to make necessary adjustments within 120 days of this survey's completion. It is felt that this is the most prudent course to pursue.

7. If you have questions or desire additional information, please telephone Glenda Taylor, Personnel Management Specialist, at FTS: 700 735-7326 or Comm: (806) 355-9703, extension 7326.

Y C PARRIS

Attachments

Appendix D

Veterans Affairs

Date:

From: Director, VAMC NY (630/00)

Subj: Annual Review of Locality Pay Schedules

To: Director, Network 3, VACO (131/0521B)

1/97

1. I have decided to continue, without increase, the current LPS salary schedules for Registered Nurse, Certified Registered Nurse Anesthetist, Nurse Practitioner and Nurse Perfusionist.

2. The only change will be within the Registered Nurse schedule: altering the beginning step of Nurse IV, Level 2 from the previous step 3 to step 5 in accordance with Circular 00-93-7, Attachment I, Supplement No 2, 5.b.

3. Response to our survey this year was poor. Like last year, we failed to find three job matches for the specialty of Nurse Perfusionist and therefore have no valid survey data. Even in the other survey occupations, there were far fewer responses than in previous surveys, but the available data indicates that steep increases in private sector salaries for nurse occupations have slowed. Many institutions have not changed their salary structure since last year.

4. Although our rates are typically lower than the private averages (especially as prorated to our 40 hour week), we have not experienced significant difficulties in recruiting and retaining qualified personnel. Indeed, changes in our patterns of patient care, coupled with budget cuts, make it very likely that we will need to reduce Registered Nurse and related positions this year through Staffing Adjustment.

5. Stable recruitment/retention and reduced budgets have led us to request that the Title V and Title 38 Special Salary rates in effect at this station not receive the national "cost of living" increase for 1997.

6. Part I and Part II of the LPS Survey Summary are enclosed.

7. If there are any questions, please call Ms. Sarah Gurwitz, Human Resources Manager, 212-686-7500, ext 7601. Thank you for your attention to this matter.

JOHN J. DONNELLAN, JR.

N003 - OK - no adjustment - did not meet minimum survey requirements

N002, N004 - no adjustment - OK - existing rates do not exceed new survey maximums.

Appendix E

Department of Veterans Affairs

Memorandum

Date: December 23, 1996

From: Acting Director, DVA Medical Center, Sepulveda, CA

Subj: Rationale for Setting Registered Nurse LPS Rates

To: Locality Pay System File

West LA VAMC (lead facility), Long Beach VAMC, Sepulveda VAMC and LA Outpatient Clinic completed a Locality Pay System (LPS) salary survey of registered nurse positions in December 1996 and West LA VAMC, Sepulveda VAMC , LA OPC and Long Beach VAMC have agreed to salary schedule effective January 7, 1996. The following rational was used to reach this decision.

This year our survey consisted of 134 hospitals, of which 28 were chosen as our random sample. Out of these 28 hospitals contacted, only 8 participated, out of these 8, six belong to Los Angeles County. This is not a good representation of our Local Labor Market, since the Los Angeles County hospitals is considered one employer with seven locations and the salary rates are the same for each of the six locations.

Nurse I: Current rate is 1.04% above community average. Recommend no increase. Turnover does exists in the LLMA, but we are able to recruit.

Nurse II: Current rate is 1.01% below community average. Recommend no increase. Turnover does exist in the LLMA, but we are able to recruit.

Nurse III: Current rate is 1.04% below community average. Recommend no increase. Data collected at this level does not reflect a good representation of our LLMA.

Nurse IV: Current rate is 1.126% above community average. Recommend no increase. Hospitals that provided data at this level did not include our major competitors, which have higher salary rates.

Nurse V: Current rate could not be established, since no data at this level was obtained.

DEAN S. BILLIK, FAAMA
Acting Medical Center Director

CONEG
COALITION OF NORTHEASTERN GOVERNORS

Governor Lincoln Almond, Chairman
Governor Argeo Paul Cellucci, Vice Chairman
Anne D. Stubbs, Executive Director

September 21, 1998

The Honorable Togo D. West, Jr.
Secretary of Veterans Affairs
Department of Veterans Affairs
810 Vermont Avenue, NW
Washington, DC 20420

Dear Mr. Secretary:

Since 1996, the Northeast States have experienced many economic and demographic changes. One of the most perplexing and unsettling of these trends has been the dramatic reduction in health services available to veterans who live here. Since the implementation of the U.S. Department of Veterans Affairs plans, *Vision for Change* and *Prescription for Change*, our veterans have been faced with radical restructuring and realignment of their important medical support - the VA Hospitals and clinics.

This restructuring has resulted in the downsizing of most hospitals, the consolidation of medical assets and the closing of some facilities. All of this realignment has resulted in sick and ailing veterans traveling great distances from rural areas to consolidated metropolitan VA medical centers. Waiting times for many essential procedures have increased and the confidence of many veterans has plummeted. Millions of dollars and hundreds of employees have been cut from veterans' facilities in the Northeast. Meanwhile, these assets are being transferred to southern states under the guise of placing assets in the locales into which veterans are moving. We feel it is unfair to decrease the care of one veteran in order to increase the care of another veteran. This is essentially what happens under the Veterans Equitable Resource Allocation (VERA) system.

During the past three years, officials from the Northeast states have met with many senior veteran leaders, members of the Northeast Congressional delegation and former Secretary Brown. Throughout all these meetings, it was agreed that something must be done about this situation yet, the problems described above continue.

On behalf of the Coalition of Northeastern Governors (CONEG), we ask you, as the Secretary of the U.S. Department of Veterans Affairs, to provide us with information on the following:

- Precisely how the interests of veterans in the Northeast were factored into the realignments and funding cutbacks in our region;

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The Honorable Togo D. West, Jr.
September 21, 1998
Page 2

- Why the VA is moving away from providing long-term care to chronically ill veterans and abrogating that responsibility to the states;

- Why VERA fails to recognize the historic higher cost of providing health care in the Northeast as compared to other regions in the nation.

We look forward to your response and to working with you in addressing the needs of our deserving veterans.

Sincerely,

Lincoln Almond
Chairman
Governor of Rhode Island

Argeo Paul Cellucci
Vice Chairman
Governor of Massachusetts

John G. Rowland
Governor of Connecticut

Angus S. King, Jr.
Governor of Maine

Christine Todd Whitman
Governor of New Jersey

George E. Pataki
Governor of New York

Jeanne Shaheen
Governor of New Hampshire

Howard Dean, M.D.
Governor of Vermont

Thomas Ridge
Governor of Pennsylvania

cc: Dr. Kenneth W. Kizer, Under Secretary for Health
Senator Arlen Specter
Senator John D. Rockefeller
Senator Christopher Bond
Senator Barbara A. Mikulski
Representative Christopher Shays
Representative Edolphus Towns

Congress of the United States

Washington, DC 20515

July 8, 1998

The Honorable Togo West
Secretary of Veterans Affairs
U.S. Department of Veterans Affairs
810 Vermont Avenue
Washington, D.C. 20420

Dear Secretary West:

We are writing to recognize the Department of Veterans Affairs on its recent step in the right direction to improve efficiency and quality in the VA New England Healthcare System – the approval of consolidation of inpatient services in Boston at the West Roxbury VA Medical Center campus. We look forward to working with you to ensure that the consolidation is efficient and effective. However, we also must emphasize the necessity of ensuring that it results in a more equal allocation of resources within the Veterans Integrated Services Network 1 (VISN 1).

As you know, Veterans Equitable Recourse Allocation (VERA) has been touted as a means of providing equal access to veterans' health care services and an incentive to the regional networks to manage workload and operations efficiently. Our veterans were patient while VA Connecticut (VA CT) went through the hardship of being the first in VISN 1 to integrate its health facilities and move towards increased outpatient care and efficiency – the very health care goals that VERA aims to accomplish throughout the nation.

The four medical centers in the Boston area also were supposed to integrate at a similar rate as VA CT, but did not do so until now. As a result, VA CT efficiencies have been supporting inefficiencies in the Boston area, draining essential resources from VA CT. Last year, due to inflation, and mandated and contractual salary increases, VA CT had a shortfall of approximately $2 million.

Now that services in Boston are beginning to move towards consolidation, we look forward to a more equal distribution of resources within the network. Proposals to more effectively reallocate these resources within VISN 1 must be among the many issues addressed as VISN 1 begins the Boston integration. We look forward to a prompt response on VISN 1 plans to redistribute its funds among its facilities. Please also be pro-active in keeping us informed on any future budgetary actions.

Sincerely,

CHRISTOPHER J. DODD
U.S. Senator

JOSEPH L. LIEBERMAN
U.S. Senator

ROSA L. DeLAURO
Member of Congress

BARBARA B. KENNELLY
Member of Congress

SAM GEJDENSON
Member of Congress

CHRISTOPHER SHAYS
Member of Congress

JAMES H. MALONEY
Member of Congress

NANCY L. JOHNSON
Member of Congress

cc: Dr. Denis J. FitzGerald

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ONE HUNDRED FIFTH CONGRESS

Congress of the United States

House of Representatives

COMMITTEE ON GOVERNMENT REFORM AND OVERSIGHT

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Statement of Rep. Christopher Shays
September 25, 1998

This is the Subcommittee's second hearing on the impact of reorganization and funding shifts on the quality of care in the Department of Veterans Affairs (VA) health system. In August of last year, we heard testimony from VA officials and veterans in Middletown, New York in response to our colleague Ben Gilman's concerns that budget-driven staff reductions and facility consolidations are limiting access, undermining quality and endangering lives at local VA hospitals.

Today, we examine similar concerns brought to our attention by our Subcommittee colleague, Mr. Allen of Maine. That state's entire congressional delegation has been pressing the VA for action on a growing volume of complaints about the quality of care at the Togus Veterans Administration Medical Center (VAMC) in Augusta. Veterans report intolerably long waits for access to specialists, critical staff shortages, uncoordinated care, and inequitable distribution of declining budget resources under the Veterans Equitable Resource Allocation (VERA) system.

In Connecticut, we have the same concerns. Our facilities are part of the same Veterans Integrated Service Network (VISN-1), and we too have felt VERA's fiscal wrath. In July, the Connecticut congressional delegation called on VA Secretary Togo West to ensure more equitable application of the VERA plan within, as well as between, regions. Like other attempts to control health care costs, notably the Medicare home health interim payment system, VERA in New England has punished efficiency, rewarded inefficiency and provided few, if any, incentives for quality, over quantity, of care.

As an oversight Subcommittee, our charge is "the overall economy, efficiency and management" of human service programs, including VA health care. We convene here today because an 18 month wait for new dentures is not efficient. Requiring elderly veterans to travel hundreds of miles for routine diagnostic tests is false, even cruel, economy. Staff shortages and poorly coordinated care point to bad management.

What do we expect from this hearing?

We expect candor, not canned speeches, about the failure to integrate inefficient Boston facilities, and the price Connecticut and Maine continue to pay for the delay.

We need to know the bottom line, not the company line, on future VERA budgets and the true cost of providing care where the veteran needs it, not hundreds of miles away where the network offers it.

And, on behalf of those who served, we demand to know that once proud facilities like Togus and West Haven will not be consigned to a slow, withering decline by bureaucratic legerdemain, but will again shine as beacons of comfort to those in need.

Welcome to all our witnesses. We look forward to your testimony.

Mr. SHAYS. I'll also say that if we have any other votes, whatever Member gets here first, just start the process, so we'll just keep moving along here.

At this time, I would like to recognize our first panel. We have Dr. Thomas Garthwaite, Deputy Under Secretary for Health, Department of Veterans Affairs; Dr. Denis FitzGerald, Network Director, VISN–1, Department of Veterans Affairs; accompanied by John Sims, Director, Togus, ME; and Vincent Ng, from New Haven, CT Health Care System. I guess it's also Wallingford as well? Wallingford as well? West Haven rather, sorry.

And that's our panelists. Is there anyone else that may respond to a question? I'd like to swear them in at the same time. So if you might be calling on someone and rather than having them whisper in your ear, and then you would put it on the record, you want them to speak directly, that would be my preference. OK? So if you'd stand and just raise your right hands, please?

[Witnesses sworn.]

Mr. SHAYS. We'll note for the record that all acknowledged in the affirmative. And I would just point out that we swear in all our witnesses, even Members of Congress who come and testify. That is a practice for everyone.

Mr. Garthwaite, Doctor, we'll start with you.

STATEMENTS OF THOMAS GARTHWAITE, M.D., DEPUTY UNDER SECRETARY FOR HEALTH, DEPARTMENT OF VETERANS AFFAIRS; DENIS FITZGERALD, M.D., NETWORK DIRECTOR, VISN–1, DEPARTMENT OF VETERANS AFFAIRS; JOHN SIMS, DIRECTOR, TOGUS, ME, VAMC; AND VINCENT NG, NETWORK DIRECTOR, VISN–14, AND FORMER DIRECTOR, CONNECTICUT VAMC

Dr. GARTHWAITE. Thank you, Mr. Chairman. I have submitted my written testimony for the record. I know you have questions, but I would like to make just five points.

First, all health care is undergoing radical change. This change is due to the rapid development of technology, to new methods of diagnosis and treatment of disease, to the extremely rapid advances in informatics and telecommunication, and to the pressures of the marketplace for simultaneously better service and lower costs. The VA is not immune from that change, nor from those pressures.

Second, the VA has more objective measures of quality than ever before. And I will argue with you that it has more objective measures of quality than any other health care system. These measures consistently demonstrate enhanced technical quality and enhanced patient satisfaction for the system as a whole.

Third, while systematic measures demonstrate overall improvement, all health care systems have examples of unplanned adverse events, and we are no different. It is our policy and our practice that adverse events, if they have negative consequences for patients, are reported, analyzed, their root cause determined and fixed, and the lessons learned shared with other VA's, and increasingly with non-VA systems.

Fourth, under congressional mandate, we developed the Veterans' Equitable Resource Allocation system, or VERA, to distribute

resources equitably among networks such that veterans would have an equal opportunity to receive care from VA, regardless of where they live across America. We recognize the difficulties inherent in the resulting shift of dollars. We have had a strategy to safeguard patients during this time as care methods and programs are adjusted, due both to the fundamental changes in health care that are occurring and simultaneously the changes in VERA funding shifts. That strategy includes capping the total funds which can move in a given period of time and maintaining reserves to help in special situations to assure quality is maintained. We also continue to examine and review the methodology itself for improvement, and that includes both internal reviews and external reviews by Price Waterhouse, the General Accounting Office and others.

Finally, I would note that change is darned hard. It is especially hard when the message is that you are too expensive. Your tendency is to feel that you're being told that you're not working hard, or what you have done previously is not valued. Neither are true. In actuality, it is likely the inefficiencies are related to redundancy in programs; to expensive practice patterns and to excess infrastructure.

History is replete with examples of industries which have undergone dramatic transformations, and rarely is that transformation smooth or painless. Health care, including VA, is undergoing such a transformation. We're working hard to assure that in that transformation, we achieve better care and better outcomes for our patients. We believe that the data demonstrate progress in that regard, but the job is not, and will not be finished any time soon.

Thank you.

[The prepared statement of Dr. Garthwaite follows:]

STATEMENT OF
THOMAS L. GARTHWAITE, M.D.
DEPUTY UNDER SECRETARY FOR HEALTH
DEPARTMENT OF VETERANS AFFAIRS
ON THE ALLOCATION OF HEALTH CARE
RESOURCES TO OPERATING ELEMENTS
AND ON
THE QUALITY OF VA CARE
BEFORE THE
SUBCOMMITTEE ON HUMAN RESOURCES
COMMITTEE ON GOVERNMENT REFORM AND OVERSIGHT
U.S. HOUSE OF REPRESENTATIVES

SEPTEMBER 25, 1998

Mr. Chairman, I am pleased to have the opportunity to review with the Committee the Department's efforts to restructure its health delivery systems; the Veterans Equitable Resource Allocation (VERA) system; and improvements in the quality of VA health care. Dr. Fitzgerald will address those issues specific to VISN 1.

I should preface my remarks by emphasizing that American health care everywhere is remaking itself. Unfortunately, there is not yet in the United States of America, nor in any other country of the world, a health care system that fully satisfies all the demands for access, quality, user service and cost. Every day we are reminded of this by stories in the media and professional journals about medical treatment errors or problems with managed care. I believe it is useful to keep this perspective in mind when we talk about ways of improving veterans health care, and especially in so far as the patients who fill VA clinics and hospitals are more medically complicated and socially needy than the U.S. population overall.

I should further note in the way of background, or perspective, that the veterans' healthcare system is unique in this country and in the world. It is not only the largest fully integrated healthcare system in the U.S., but it is also among the most complex healthcare systems in the world because of its multiple missions – missions which are at the same time complementary, competing and conflictive. [See Attachment]

VHA Reengineering

To address multiple public criticisms and to capitalize on and enhance VA's many strengths, we have been engaged in a systematic effort to fundamentally re-invent VA healthcare. This three year effort, which has a primary aim to improve both quality and efficiency, or value, has involved reengineering VHA's operational structure, diversifying its funding base, streamlining processes, implementing "best practices," improving information management, reforming eligibility rules, expanding contracting authority, and changing the culture of VA healthcare, among other things.

At this time, many critical actions have been completed or are well underway. In fact, I believe that no other healthcare system in the U.S. can match the extent of change that has occurred in the veterans healthcare system since our efforts to restructure the system were launched in late 1995.

To exemplify this, let me cite a number of facts and figures that attest to the nature of the changes and improvements that have occurred:

- VA's now approximately 1,100 sites of care delivery have been organized into 22 Veterans Integrated Service Networks (VISNs), and the VISNs are now the system's basic operating unit. (VA medical care assets include 171 hospitals, 133 nursing homes, about 600 ambulatory and community-based clinics, 40 domiciliaries, 206 counseling centers, 73 home health programs, and various contract treatment programs.)
- Beginning with about 10% of patients enrolled in primary care at the end of 1994, universal primary care has been implemented, as well as universal telephone triage or "call centers."
- Between September 1994 and May 1998, 48% (24,956) of all VA acute care hospital beds were closed.
- Compared to FY 1994, annual VA inpatient admissions in FY 1997 decreased 24% (247,412), while ambulatory care visits increased by 23.8% (6.1 million) to a total of 32.6 million outpatient visits in FY 1997.
- Between October 1995 and March 1998, VA bed days of care per 1,000 patients decreased 61 percent (nationally) – from 3,530 to 1,370. This rate is now 5-10% lower than the rate for Medicare.
- Between December 1994 and March 1998, VHA's staffing (FTEs) decreased 11% (23,832), while the number of patients treated per year increased by over 10% (approximately 300,000). During this same time, about 8% more psychiatric/substance abuse patients, 19% more homeless patients and 20% more blind rehabilitation patients were treated.
- Ambulatory surgeries increased from 35% of all surgeries performed in FY 1995 to about 75% in mid-FY 1998. Associated with this, has been increased surgical productivity and reduced mortality.

- Since the fall of 1995, the management and operations of 48 hospitals and/or hospitals and clinic systems have been, or are in the process of being, merged into 23 locally integrated systems.
- A new capitation-based resource allocation methodology (the Veterans Equitable Resource Allocation system or VERA) has been implemented and validated.
- Since 1994, 22% (27 of 121) of PTSD treatment programs have shifted, or are in the process of shifting, from inpatient to outpatient.
- Since 1994, 59% (112 of 190) of substance abuse treatment programs have shifted, or are in the process of shifting, from inpatient to outpatient programs.
- During the 3-year period FY 1995-1997, over 2,700 (67%) of VHA forms were eliminated, and all remaining forms and directives were converted to CD-ROM or other electronic means.
- Customer service standards have been implemented, customer satisfaction surveys are being routinely performed, and management is being held accountable for improving service satisfaction. Statistically significant improvements have been documented. (In FY 1997, 65% of all inpatients – including psychiatric patients – reported the quality of their VA care as very good or excellent.)
- A pharmacy benefits management program implemented in FY 1995, which includes a national formulary, has produced an estimated cumulative savings of over $347 million on the purchase of pharmaceutical products.
- Other elements of a Commercial Practices Initiative are yielding tens of millions of dollars of savings in the acquisition of medical and surgical supplies, prosthetics, equipment and maintenance, renal dialysis and support services.
- 216 new community-based outpatient clinics (CBOCs) have been sited, or are in the process of being sited, from savings achieved in other areas. (Many of these are by contract with private providers.) In addition, 30 counseling centers have expanded their services to include medical and primary care. Approximately 200 more CBOCs are anticipated to be established in the next 24 months.
- A new system-wide Decision Support System (cost accounting system) has been fully implemented at 91 VA hospitals and is in the final phases of implementation at the remainder of the hospitals.
- Universal pre-admission screening and admission and discharge planning have been implemented, along with many other "infrastructure" and process changes, such as a universal, semi-smart identification and access card.
- "Hoptel" or temporary lodging beds have been established at all VA hospitals.

- Each year for the period 1995-97, the VHA's worker compensation expenses decreased, yielding an aggregate 3 year savings of $8.5 million (5% decrease), and reversing 13 years of consecutive increases. (This contrasts with an increase in the average worker compensation costs for all federal agencies for the same period.)
- A new series of specialized mental health centers called "Mental Illness Research, Education and Clinical Centers" (MIRECCs) patterned after the highly successful "Geriatrics Research, Education and Clinical Centers" have been established. Two MIRECCs were designated in FY 1997; another 3 will be opened by October 1999.
- Several new graduate medical education programs have been, or are being, inaugurated, including a new health systems quality management fellowship and two new "primary specialist" programs to train specialists to provide primary care. Likewise, special fellowships have been started in medical informatics and palliative care. VA's commitment to support training in preventive medicine, medical toxicology and occupational and environmental medicine has also significantly increased.
- Of the 8,910 postgraduate physician residency positions that VA funded in Academic Year (AY) 1996, 250 have been abolished and 750 specialist positions are being redirected to primary care, so that in AY 1999, about 49% of VA funded residency positions will be in primary care (compared to 37% in AY 1996).
- VA's intramural research program has been restructured, and while the program's funding increased only 4% from FY 1995 to FY 1997 ($251M to $262M), 30% more merit review projects have been funded, 2 additional rehabilitation R&D centers have been established, 15 new cooperative studies were begun in FY 1997, a new nursing research initiative was launched (FY 1996), and many new studies and health services research projects have been initiated.

Quality of Care

A central tenet of our reinvention effort has been to improve the consistency and predictability of the quality of care that is provided. To that end, the Veterans Health Administration has been assembling a system of data collectively referred to as a "performance measurement system." This system becomes more elaborate year by year and today permits us to know in many ways how well we are improving the quality of care. Current data show that the quality of VA healthcare has measurably improved in the last three years. In fact, using standard quality of care measures employed in the private sector, VA performance is superior across the board.

For example, VHA's Preventive and Chronic Disease Care Indexes are analogous to the HEDIS instrument used in the private sector (minus measures related to pediatric and obstetrical care), although the indexes evaluate VA's performance for several important indicators not routinely tracked by private providers. Illustrative of this

latter point, VA is setting the national benchmark for all healthcare systems by mandating and monitoring the use of standardized instruments to screen for alcohol abuse and to assess the functional status of substance abusers.

The Prevention Index consists of 9 quality outcome indicators that measure how well VA follows national prevention and early detection recommendations for diseases having major social consequences such as cancer, smoking and alcohol abuse. Compliance with these recommendations nearly doubled in FY 1997 (from 34% to 67%). On average, VA outperforms the private sector on all indicators where comparable data exist, ranging from being 5% to 69% better on individual quality indicators. In addition, VA surpassed the U.S. Public Health Service Healthy People 2000 goals for 5 of the indicators. These positive trends have continued in FY 1998.

The Chronic Disease Care Index consists of 14 quality outcome indicators that measure how well VA follows national guidelines for high volume diagnoses such as ischemic heart disease and diabetes. Percentages reflect the number of patients who actually receive a required medical intervention. The Chronic Disease Care Index in the aggregate rose 73% in FY 1997. Again, where comparable data exist, VA consistently outperformed the private sector, ranging from being 21% to 124% better on individual quality indicators. Examples of VA versus private sector performance include the rate of aspirin therapy for patients with heart disease (92% vs 76%) and the percentage of diabetics whose blood sugar control is monitored annually by a blood test (85% vs 38%). As with the Prevention Index, continuing VA improvement has been demonstrated in FY 1998.

As part of our re-inventing effort, we have also been tracking the 1-year survival rates for 9 high-volume medical conditions. These conditions affect some of our most vulnerable patients. Survival rates for the time period Fiscal Years 1992-1997 for several of these important conditions have increased (i.e., congestive heart failure – a 9% increase to 83.5%, chronic obstructive pulmonary disease – a 4% increase to 88%, pneumonia – a 7% increase to 89%, and chronic renal failure – an over 9% increase to 81.4%), while rates for the other conditions have remained stable (i.e., diabetes mellitus – 95%, angina pectoris – 97%, major depressive disorder – 99%, bipolar disorder – 99%, and schizophrenia – 98%).

In this regard, I might also note that a "VA Clinical Programs of Excellence" program has been established. This program recognizes the best practices in American healthcare, as demonstrated by clinical outcomes, processes, resource utilization and service satisfaction; 36 VA clinical programs across the country were designated as Programs of Excellence in October 1997.

In yet another area, morbidity and mortality rates of high volume surgical procedures in the VA have consistently declined in recent years. Mortality rates for colectomy, abdominal aortic aneurysm repair, carotid endarterectomy, cholecystectomy and hip replacement are the lowest, or equal to the lowest, in the country according to a 10 year review of published studies of surgical outcomes done by Dr. Shukri Khuri, Chief of Surgery at West Roxbury, VAMC and Professor of Surgery at the Harvard University School of Medicine.

In the three years since VA's National Surgical Mortality and Morbidity Program was implemented, the overall 30-day mortality and morbidity rates in VA surgical programs fell by 10% and 28%, respectively. (During this time there was no change in the patient risk profile.) Several articles about these improvements were published in peer-reviewed medical journals last fall, and an editorial by the Chairman of Surgery at Duke University endorsed VA's approach as one that will improve the quality of surgical care throughout the nation.

VA is also leading the country in defining and measuring care at the end of life. We are using a newly developed instrument known as the Palliative Care Index. This index consists of various quality of care indicators that reflect the adequacy of end of life planning for patients with terminal conditions. It was for remarkable improvement in this area that VHA received the first of its kind commendation from the organization, Americans for Better Care of the Dying, in December 1997.

Finally, I should note that our Northeast Program Evaluation Center, which is located in West Haven, Connecticut, has just completed a comparison of the quality of VA's mental health services with data from the Medstat Group's Marketscan® Data Base, which provides information on the behavioral health performance of over 200 private insurance companies. This comparison was possible because of the Mental Health Program Performance Monitoring System that VA implemented in 1995. In brief, while VA has longer lengths of stay than observed for private sector mental healthcare providers (most likely because of the more severe psychiatric illness and social disadvantage of VA patients), VA's performance is comparable to or superior to the private sector on most of the measures of coverage, service delivery, efficiency and service satisfaction. Continuity of care was notably superior in VA.

Data such as these are encouraging and indicate to us that the change processes designed to improve quality of care in VHA are heading in the right direction. A recent article in the New England Journal of Medicine detailed the analysis of administration of beta-blocker therapy in Medicare patients with ischemic heart disease (also called heart attacks or angina). Their data shows that mortality is 40% lower for those who received beta-blockers, but only 34% of Medicare patients actually received the drug.

Not accidentally, VA's Chronic Disease Care Index that I mentioned earlier also tracks the use of beta-blockers as a therapy for ischemic heart disease. Data show that VA patients received beta-blocker therapy 71% of the time in 1995—over twice the Medicare rate—and by the first half of 1998, VA's rate had climbed to 87%--over two and one-half times the 1995 Medicare rate. When one compares a group of 4000 VA and Medicare patients with ischemic heart disease using the 1995 data, 3365 VA patients and 3245 Medicare patients survived more than two years—a difference of 120 people! By 1998, the number of VA patients surviving for more than two years with ischemic heart disease will have climbed to 3417—an additional 52 people. Said another way, if this group of 4000 veterans had received Medicare financed care in the private sector in 1998, 172 of them would have had their lives shortened.

The higher rate of beta-blocker therapy and improved outcomes happened because of the concerted effort underway in VHA to measure and improve quality. We

now know how often our clinicians prescribe beta-blocker therapy because we measure this activity along with scores of others. We believe the rate continues to go up because performance levels are prescribed and Veterans Integrated Service Network (VISN) directors are held accountable for achieving those levels. For example, the fully successful level for the Chronic Disease Care Index in Fiscal Year 1999 is 90%, and the rate of administration of beta-blocker therapy contributes to that score along with many other measures. In short, VA's patients with ischemic heart disease live longer because VA measures the performance of its clinicians and holds people accountable for achieving performance standards.

Veterans Equitable Resource Allocation (VERA)

VA implemented the Veterans Equitable Resource Allocation (VERA) system in April 1997 to more equitably allocate VA healthcare resources among different regions of the country. Prior to that time, resource distribution was based primarily on historical costs and not on an assessment of needs across the entire country. As a result, we had many facilities that were over funded and many others that were underfunded for the workload that they were performing. We also had significant regional variations in veterans' access to our services. Numerous reviews, including those of the General Accounting Office, documented these problems. As a result, VA's FY 1997 Appropriation Act (Public Law 104-204) required VHA to develop and submit to Congress a plan to allocate funds in an equitable manner.

VERA rectifies problems perpetuated by previous funding systems by providing networks with two national workload prices for two types of patients – those with routine (Basic Care) needs and those with complex/chronic healthcare needs (Complex Care). In FY 1998, networks receive $2,604 for each Basic Care patient and $36,960 for each Complex Care patient. This ensures that VA's patients with special care needs are funded appropriately. For example, VISN 1 receives more Complex Care funds than 15 other VISNs because they have the seventh highest number of these patients.

VERA is based on validated patient workload and includes adjustments for variances in labor costs, research, education, equipment and facilities maintenance needs. Network budgets are also adjusted to account for those veterans who receive care in more than one network.

The results of VERA for the FY 1997 and FY 1998 allocations to networks were as follows:

- For FY 1998 (the first full year of VERA), 13 networks received increases over funding levels for FY 1997. Nine networks received less funding. Network reductions were limited to 5%. Comparing FY 1998 funding with FY 1996 (the baseline year for VERA), fifteen networks have received overall increases while seven networks have received decreases. Six of the networks have increased ten percent or more with the greatest increase at 12.3 percent.

- Since July 1997, all collections from third party reimbursements, co-payments, per diems and certain torts are retained by the collecting network. During early FY 1998, a system-wide target of $688 million in these Medical Care Collection Fund (MCCF) receipts was projected to be transferred to the Medical Care Appropriation and would remain available until expended. When estimated MCCF collection transfers and other reimbursements, such as Tricare and sharing, are added to VERA totals, the smallest percentage change from FY 1997 in funds available is estimated to be +0.10% in VISN 3 (Bronx, NY), with VISN 1 (Boston, MA) at +1.21%, while VISN 16 (Jackson, MS) is expected to experience the greatest percentage change in total funding with +10.38%.

- With the 5% cap on VERA losses in place, it is expected all funding inequities will be corrected by FY 2000, and VERA will have shifted $500 million across VHA's healthcare system over four years. (Most will be corrected by FY 1999.)

VERA is not simply moving all networks to an average cost per patient. Variances from the national average will exist because VERA allocates funds in a manner that adjusts for differences in patient mix, labor costs, and research and education support costs. Thus, even the networks that have less funding in FY 1998 compared to FY 1997 may still be provided a higher than average price per patient than networks that receive more funding. For example, VISN 3, which would receive 12.2 percent less funding under full VERA, has an average price of $5, 659, which is 26.7 percent above the system average of $4,465. Conversely, VISN 18 (Phoenix, AZ), which would receive 11.4 percent more funding under full VERA, has an average price of $3,886 per patient, which is 13 percent below the system average. VISN 1, which would receive 5.42 percent less funding under full VERA, has an average price of $4,886 per patient, which is 9.4% above the system average.

The results of the preliminary FY 1999 network allocations based on the President's FY 1999 Medical Care Budget Request is as follows:

- Thirteen networks would receive VERA increases over funding levels for FY 1997. Nine networks would receive less funding. Network reductions are again limited to 5%.

- The largest positive VERA shift is VISN 8 (Bay Pines, FL) with an increase of 2.25%, which equates to a gain of $24.1 million. The largest negative shift is VISN 3 with a decrease of 4.97 percent, which equates to a loss of $48.4 million. VISN 1 has a decrease of 4.80 percent, which equates to a reduction of $38.8 million.

- System-wide, $625 million in MCCF transfers and $147 million in other reimbursements are estimated to be available in FY 1999. When estimated FY 1999 MCCF collection transfers and other reimbursements are added to VERA totals and compared to FY 1998 initial funding levels, the largest positive resource shift is VISN 8 with an increase of 2.12% or a gain of $24 million. VISN 3 has the largest

negative resource shift with a decrease of 4.82% or a loss of $49 million. VISN 1 has a reduction of 4.35% or a loss of $38 million.

These preliminary allocations were distributed by VHA Headquarters to the 22 networks on July 27, 1998. The allocations will be updated after the Congress passes the FY 1999 Medical Care Appropriation. If Congress approves either the House or Senate Action (or a level in between) on the FY 1999 Appropriation, VISN 1 would receive additional funding.

Additionally, as was done in FY 1997 and FY 1998, we are maintaining a $100 million national funding reserve in VA headquarters to assist networks in the unlikely event that the current level of patient care is threatened. The reserves will be used, if needed, to maintain the quality and level of services. Should the quality and level of service not be threatened, the reserve will be distributed to the networks during the fiscal year in proportion to the overall VERA budget.

While VERA is an effective methodology for allocating resources at the network level, it is recognized that VERA may not be as useful to the networks at the facility level. This is due to significant differences at the facility level that, in the aggregate, are not a factor when allocating at the network level. Among the factors that significantly affect facility-level healthcare environments are: size, mission, and location of facilities; levels of affiliations with academic institutions; efficiency of operations; proportions of "shared patients;" and patient complexity and case mix. As a result, in FY 1998, the Under Secretary for Health issued a directive establishing principles to guide the allocation of resources at all levels in VHA that move the organization toward accomplishing its system-wide goals and objectives. VISNs used the following guiding principles in providing allocations below the network level for FY 1998 and will again be guided by these principles for the FY 1999 allocations. Network allocation systems must:

1. Be readily understandable and result in predictable allocations.
2. Support high quality health care delivery in the most appropriate setting.
3. Support integrated patient-centered operations.
4. Provide incentives to ensure continued delivery of appropriate special care
5. Support the goal of improving access to care.
6. Provide adequate support for the VA's research and education missions.
7. Be consistent with eligibility requirements and priorities.
8. Be consistent with the network's strategic plans and initiatives.
9. Promote managerial flexibility, (e.g. minimize "earmarking" funds) and innovation.
10. Encourage increases in alternative revenue collections.

External reviews of VERA have reflected positively on our progress to date:

- In the Spring of 1997 Senator "Kit" Bond, Chairman of the VA – HUD Senate Appropriations Subcommittee said: "...VA has overhauled its allocation

methodology, vastly improving fairness and appropriateness with which resources are allocated to facilities ...the new system is a tremendous step forward.

- In late 1997 the GAO reported that VERA is making resource allocation more equitable than previous allocation systems.

- In March 1998 Price Waterhouse LLP issued a report on its evaluation of VERA. The report concluded that VERA was a well designed system, is ahead of other global budgeting systems, and met VHA's goals of simplicity, equity and fairness. It also found that the conceptual and methodological underpinnings of VERA were sound.

We are continually reviewing VERA to assure that our healthcare resources are allocated in a manner that moves the VA system toward our goal of having equity of access to our services in all regions of the country, and in a manner that achieves the greatest return for the investment to taxpayer dollars.

Mr. Chairman, this concludes my statement. I and my colleagues will be pleased to respond to your questions.

ATTACHMENT

Missions of VA Healthcare

Today, the veterans healthcare system fulfills five principle roles, four of which are statutory, and the fifth of which underscores the inherently governmental and public benefit nature of the system.

The specific missions of VA healthcare are:

(1) First, to provide medical care to veterans, although for many years these services have been limited to veterans having service-connected disabilities and/or who are poor. These veterans constitute about 37 percent of the U.S. veteran population (about 9.4 million of 25.1 million veterans).

(2) Second, to conduct health professional education and training. Today, the Veterans Health Administration (VHA) is the largest single provider of health professional training in the world. In addition to providing training to half of the nation's medical students and one-third of postgraduate physicians each year, VHA also provides training for over 54,000 pharmacists, podiatrists, optometrists, nurses and more than 40 other types of healthcare professionals every year. While veterans clearly benefit from this relationship with academic medicine, the public at large gains even more.

(3) Third, to conduct research that benefits veterans. Without question, VA is one of the largest and most productive research institutions in the nation. Many landmark discoveries have been made by VA scientists and medical investigators or have their roots in work done by the VA. Hardly a week goes by that VA research is not published in the nation's top medical journals. While VA research certainly benefits veterans, it also greatly benefits everyone else.

(4) Fourth, to provide contingency support to the Department of Defense (DoD) and the Public Health Service (PHS) during times of disaster or national emergency. With the downsizing of the DoD and its ever present readiness needs and with the elimination of the PHS and Indian Health Service hospitals, the simple fact is that VA is the federal government's principle asset for providing medical assistance for large-scale natural or technological disasters. Once more, the public at large is a principle beneficiary.

(5) Finally, VHA's unofficial, but important fifth mission is to provide medical services and other support for homeless veterans. Today, VHA is the single largest direct care provider for homeless persons in the country, and we are a critically important – although often unrecognized – element in the nation's public safety net.

These various missions of the VHA have evolved over several decades as a result of myriad public policy and programmatic decisions. And it is no accident that so much of what VA does today is inherently governmental and/or provides a public benefit that goes well beyond providing just for the medical care needs of veterans.

Mr. SHAYS. Dr. FitzGerald. Before you speak, I'm going to be calling—first I want to just recognize the presence of Chairman Ben Gilman, who kind of started us in this process, actually brought the committee up to New York; and it was a hearing I'll never forget. And I'm going to invite him to make a statement after you've addressed us. And also my colleague, Rosa DeLauro, who actually represents the facility in West Haven; and it's wonderful to have her here as well. So I'll invite both of you to make a comment as soon as we hear from you, Dr. FitzGerald.

Dr. FITZGERALD. Thank you very much. Mr. Chairman and members of the committee, I appreciate the opportunity to appear before you today. I look forward to discussing the high quality of care delivered in VA New England, and to addressing our plans to maintain and enhance the quality of care within VISN–1.

Network 1 is charged with providing services to veterans within the six New England States in diverse geographic locations which span the spectrum from densely populated urban centers to sparsely populated rural areas. Our programs and personnel provide the full spectrum of health care services from out-patient primary care to complex tertiary and coordinated care.

Despite projections that conclude that there is a decreasing number of veterans within New England, we have, in fact, experienced an increase in the number of out-patient visits and in the overall number of veterans being served. Our strategic plan calls for the VISN to rethink and redesign and realign VA assets to meet patients' needs in the most effective and efficient manner within available resources. By placing the veteran at the center of all we do, by development of network service lines, and by the application of performance measures and clinical guidelines, network management is developing essential systems of care. These systems create the medical environment necessary to ensure that comparable clinical care of consistently high quality is available and practiced universally throughout our network.

As mentioned in my pre-hearing testimony, the excellent results obtained from our quality outcome, process, and structural measures and our consistently high patient service and satisfaction scores validate our approach and indicate that the care delivered throughout VISN–1 is of superior quality.

In addition, to facilitate our network's transformation to the new VA, and to integrate the existing capacity of the divisions into a coordinated regional network that meets the needs of veterans in local markets, the VISN leadership introduced several network-wide systems. These critical systems and their impact on veteran care are previously discussed in my pre-hearing submission. As a result of the implementation of these changes, veterans in New England will benefit by an increase in the availability of more primary and specialty out-patient services of superior quality at all divisions. A standard package of basic benefits will be available at all major sites. The full range of services from primary care to highly specialized tertiary services will be available within the VISN. In addition, improved communication and referral procedures will facilitate both patient treatment and patient movement along the continuum. Better coordination of transportation systems and clinical appointment schedules will improve access for veterans

and eliminate unnecessary delays in obtaining care. When the VA cannot provide services, the coordination of care with local community providers will help expand the availability of care at the local level.

Finally, the continued establishment of CBOC's throughout the network will substantially improve local access to care for a significant number of veterans. In sum, the impact of these changes not only improves the quality of care available to the veterans of New England, but also helps move VISN–1 toward our goal of providing the most veterans with the right care, in the right place, at the right time, and at the right cost.

We have embarked on that journey, and we, as Dr. Garthwaite has indicated, over the period of time hope to continue to improve our services and the convenience to our customers.

Thank you for inviting me to speak before you today. I appreciate your support for our benefits and our efforts to provide the best possible care to our Nation's veterans. I'd be pleased to answer your questions that you may have. Thank you very much, Mr. Chairman.

[The prepared statement of Dr. FitzGerald follows:]

Statement of

Denis J. FitzGerald, MD, MHA

Network Director (VISN 1)

VA New England Healthcare System

Department of Veterans Affairs

Before the Subcommittee on Human Resources

Of the

House Committee on Government Reform and Oversight

September 25, 1998

Mr. Chairman and members of the Committee, I appreciate the opportunity to appear before you today. I look forward to discussing not only the high quality of care delivered in the New England Healthcare System (VANEHS) and how we measure it, but also any related issues about which you may have received expressions of concern. In addition, I would be pleased to address how we plan to maintain the quality of care within our VISN as our new "integrated" structure continues to evolve.

VISN 1, the VA New England Healthcare System (VANEHS), 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 this Country. These include Harvard, Yale, Brown, Dartmouth, Boston University, Tufts, and the Universities of Massachusetts, Connecticut and Vermont Medical Schools. Our programs and personnel provide the full spectrum of healthcare services from outpatient primary care to complex tertiary and quaternary care. Among these services are many special programs such as Spinal Cord Injury, Open Heart Surgery, Domiciliary care, Compensated Work Therapy, Blind Rehabilitation and a model program for addressing the needs of Homeless veterans, to name but a few.

VANEHS is charged with providing services to veterans in diverse geographic locations which span the spectrum from the densely populated urban centers of Boston and West Haven to the sparsely populated rural areas of Maine, Vermont and New Hampshire. In addition, from a demographic and socio-economic perspective, the health of New England veterans parallels similar non-veteran cohorts within the general population. As a result, the clinical care expectations and delivery system challenges facing VISN 1 represent a cross section of American healthcare and bring together all of the issues found in different regions throughout the VA. In addition, despite projections and studies that conclude that there is a decreasing number of veterans within New England, the overall workload has not declined considerably in the past few years. Our VISN, in fact, has experienced an increase in the number of outpatient visits and the overall number of veterans being served.

After an extensive study and evaluation in October 1995, Congress approved implementation of the Veterans Health Administration reorganization plan. As with all changes undertaken by VHA, the purpose of the reorganization was, and is, to improve the overall well being of those veterans who seek our help. The VA New England Healthcare System (VANEHS), VISN 1, is accomplishing this mission by placing the veteran - our patient - at the center of all we do and by rethinking, redesigning and realigning VA assets to meet patient needs in the most effective and efficient manner within available resources. Under this construct, the Network is responsible for and entrusted with the development, maintenance and performance of the necessary systems, protocols and guidelines that will ensure comparable clinical care of consistent high quality across the Network and that will add value to every patient encounter.

Through the development of network service lines and the application of performance measures and clinical guidelines, VANEHS management is creating the systems of care and the medical environment necessary to ensure that high quality care is available and practiced universally throughout the network. Our extensive involvement in professional education and clinical research, when linked with our close affiliation with numerous prestigious Medical Schools, further contributes to the quality and richness of the practice environment found throughout Network 1. The result is that in VISN 1, clinical interactions are coordinated and managed across the continuum to meet measurable best practice standards and prospectively negotiated outcome expectations.

Operationally, "value" is defined as achieving an optimal balance among three critical, yet dynamic, parameters: clinical and functional outcomes; patient satisfaction and service; and costs. Where clinical and functional outcome parameters are not yet available, process and / or structural quality measures are used. Ultimately, as our Network evolves and matures, all clinical and administrative decisions will focus on patient need and be designed to add value to each patient - caregiver interaction. The result will be measurably better clinical and functional patient outcomes, greater patient and professional satisfaction, and lower operational costs ...the right care, in the right place, at the right time, and at the right cost.

Clearly, to accomplish our approved mission and vision requires a significant shift in the VAMC's traditional approach to providing services. To facilitate that transformation and to integrate the existing health service programs and the capacity of the divisions into a coordinated, regional network that meets the needs of veterans in local markets, the VISN introduced several network-wide systems.

STANDARDIZATION OF HEALTH CARE

To help standardize the delivery of healthcare throughout VISN 1 and to expedite the transition to ambulatory care and outpatient services, an ambulatory service

line was developed. This service line, and the others, which will follow, ensures that veterans receive comparable care of consistently high quality across the Network. In addition, the Network has instituted 23 clinical practice guidelines and protocols which foster better clinical outcomes, greater patient satisfaction, and lower costs.

OUTREACH

To reach out to the veteran population, to become a more friendly and convenient provider, and to improve patient access, the Network has provided guidance and funding for the establishment of several Community-Based Outpatient Clinics (CBOCs) located in veteran population centers that are distant from existing VA facilities. Among the newly activated CBOCs in VISN 1 are Portsmouth, NH; Hyannis, Lynn, Haverhill, and Framingham, MA; Waterbury and Stamford, CT; Bennington, VT; and Rumford, ME. Additional CBOCs are in the planning stages and will continue to be placed in local communities when there is a demonstrated need for such services. As a supplement to these permanent clinic sites, the Network encourages and incentivizes the provision of screening clinics and health fairs at a variety of locations across New England to better serve our veteran population.

TRANSPORTATION AND REFERRALS

For those patients who require referral to another VA medical center, the Network has coordinated, enhanced and formalized an interfacility transportation system. This system is designed to ease the burden and inconvenience for the veteran when a referral cannot be avoided. It enables veterans to go to their local VA medical site and be transported by the VA to the VA referral destination and then be returned when their appointment or treatment has concluded. The transportation system also provides for the regular and timely transfer of lab samples, supplies, mail and other packages that must be moved between medical centers. In addition, the system enables us to move healthcare providers to the patient when that is appropriate. Several specialists currently travel from Boston and White River Junction to provide outpatient clinics at the Bedford, Brockton, and Manchester sites and from Brockton and Providence to provide services at the Hyannis site. This system facilitates the veteran's ability to receive specialty care at their local VA and minimizes the number of veterans who have to travel to a referral hospital for their care. Interfacility cooperation of this type will continue to be coordinated and encouraged by the Network.

When it is not practical for VA staff to travel to the patients, each Division is encouraged to explore the possibility of providing services locally through contracts or sharing agreements with local providers. Our goal is to provide as much care as possible in the local area, consistent with best clinical practices. Examples of Network-guided innovative approaches to improve local access include: the agreement between Newington and the University of Connecticut to

provide ambulatory specialty care, ambulatory and inpatient surgery, and medical hospitalization; and the agreement between community providers at three MRI sites and a radiation therapy site and VAMC Togus to provide those services to the Maine veterans. However, this approach must be balanced with our obligation to use available resources in the most effective and cost efficient manner to provide the most care for the most veterans.

INFORMATION TECHNOLOGY

The standardization and appropriate application of advanced information technology has made possible the convenient access to an enhanced quality of care in rural areas and the improved coordination and continuum of care. We have implemented telemedicine and teleradiology systems that allow physicians from remote locations to transmit images of patients or x-rays to specialists at major VA facilities in VISN 1 to assist with the diagnostic and therapeutic process. This offers the patient another mechanism to receive care in the local community while still having access to highly specialized expertise that would not previously have been available without traveling to a tertiary care medical center.

In addition, our telephone systems now allow veteran access to VA medical centers and professional staff 24 hours a day. Using clinically determined protocols, veteran health questions and needs can often be satisfied

immediately. Use of this telephone system is often effective in obviating the need for a visit; in providing helpful healthcare information; in improving patient compliance with treatment regimes; and in preventing potential problems.

Recently, the VISN concluded a telephone based pilot study that offers disease-specific information. Designed to educate and involve the patient in his or her treatment decisions, this program is available at three sites, 24 hours per day. If data analysis proves that the program adds value to our patient users, we will expand the program to all sites in VISN 1.

As an integrated healthcare system serving a defined veteran population, we must provide our clinical staff with the ability to access patient information as needed. To that end, we have significantly upgraded our information systems to facilitate the sharing of complete, accurate information about any patient among all VA Medical Centers in VISN 1. This expedites the consult, referral and feedback process to ensure each patient's care is managed appropriately by his primary care team and all pertinent information is available to any provider involved in the care of the patient.

As a result of the system and process changes discussed above, veterans in New England will benefit by the availability of more primary care and specialty outpatient services in all VISN 1 facilities. A standard package of basic benefits

and services will be available at all sites. The full range of services from basic primary care to highly specialized tertiary services will be available within the VISN. Improved communication and referral procedures between hospitals will facilitate patient treatment and movement along the continuum of care. Better coordination of all transportation systems and clinical appointment scheduling will improve access for veterans and eliminate unnecessary delays in obtaining care. In addition, coordination with local community providers, in circumstances when VANEHS cannot provide services, will help expand the availability of care at the local level. Finally, the continued establishment of CBOCs throughout the Network will substantially improve local access to care for a significant number of veterans. In sum, these changes are helping to move VISN 1 toward our goal of providing veterans with the right care, in the right place, at the right time, and at the right cost.

As we implement these network-wide systems, process and system improvements, uniform quality criteria, standards of care, practice guidelines, performance measures and outcome monitors are applied. The ability to impose consistent procedures across a network of hospitals is one of the major benefits of the new VISN organizational structure.

Prior to the activation of the Networks, each VA facility operated to a significant extent in isolation from other VA Medical Centers. Standards of care and quality

monitors were often developed or interpreted locally and they often relied on different databases from one facility to the next. While each facility had a systematic approach to measuring and monitoring the quality of care being provided, it was difficult to make comparisons among facilities or review performance without understanding the sources and definitions of the information being reviewed. This diminished the reliability of many reports that were collected at the national level.

Consequently, in light of this situation, we initially relied on each Medical Center to monitor and report on the quality of care they provided. In addition to these internal systems, we looked to VISN level reviews and external reviewers such as the External Peer Review Program, the Joint Commission on Accreditation of Healthcare Organizations (JCAHO), the Office of the Medical Inspector, the Inspector General, and site visits by Veteran Service Organizations to validate the quality of care being provided at VISN 1 Medical Centers.

Based on our goal of providing comparable, high quality care throughout the VISN, we began the process of developing and implementing uniform criteria, definitions, standards, databases, and other measures to ensure consistency of care and quality across the VISN. Quality has been the major focus of our initiatives since the VISN was formed in 1995. This emphasis on quality and consistency extends beyond the Networks to VHA at the national level. By establishing and applying national standards, performance measures, quality

monitors, outcome indicators, and healthcare industry benchmarks to all VISNs, the VHA has demonstrated its commitment to improving quality within the "new VA". All VISNs have been assigned performance standards they are expected to meet on an annual basis. In Fiscal Year 1997, VISN 1 was rated second among all 22 VISNs in overall performance. For the first three quarters in FY 1998 VISN 1 is currently at or above the national average for most performance measures and is again near the top of the list for all VISNs.

The above achievement is the result of significant time and effort being devoted to improving our performance. We implemented a process that involves weekly conference calls, periodic network-wide meetings, and regular feedback of current performance data to all facilities in VISN 1. This ensures continuous attention to quality issues and provides numerous opportunities for addressing concerns, sharing ideas, offering suggestions, recommending solutions to problems, and discussing general information related to quality.

More specifically, the VISN 1 value scorecard of clinical and functional outcome measures includes the following outcome results:

- From The Cohort Based Analysis of Utilization and Survival Rates across VA Healthcare between 1992 - 1996: the early year results from this study reveal that VISN 1 is consistently a high outlier in inpatient and outpatient resource use. The latest data (1996) reveals that over the period studied VISN 1 has shown substantial improvement in resource use while maintaining among the

lowest mortality rates in the Nation. The results of this study provided the rationale for our first 18 Network clinical practice guidelines.

- From The 1997 National Health Outcomes Study: This study which was conducted by the VA Health Systems Research and Development Organization used a SF36 patient evaluation instrument to determine the outcomes of care as perceived by veterans. More specifically, this tool measures veterans' perceptions of their functional level post treatment. Overall, the study concluded that VISN 1 functional outcomes were among the best in the Nation. VISN 1 was the leader in the area of Mental Health and was among the top quartile in functional outcomes in Medicine and Surgery.
- From The National Surgical Quality Improvement Program (NSQIP): This study demonstrates that surgical care provided in VISN 1 meets or exceeds quality standards.

Process quality indicators include elements of the Chronic Disease Index (CDI) and the Preventive Index (PI):

- From the Performance Measures, CDI, and PI: During the first three quarters of 1998, VISN 1 continued to make significant improvements in the overall CDI and PI and remained at or above the VA national percentage score in both areas. Significant gains were made in the elements of hypertension and obesity monitoring within the CDI and tobacco use and immunization parameters in the PI.

- From the Veterans Health Survey from the National Center for Health Promotion (1997 - 1998): This study indicates that between 1997 and 1998 VISN 1 significantly improved in 24 out of the 28 measured parameters and met or exceeded the National VA score in 23 of 28 indicators. Currently, VISN 1 meets or exceeds 61% of the 28 VA goals for the year 2000. These measurements are an indicator of our veterans' understanding of and participation in their preventative, disease monitoring and treatment programs. This represents an independent validation of the VISN's performance on the CDI and PI from the patient's perspective.

In addition to the above national outcome studies and process measures, there are structural measures of quality that support our contention that the quality of care provided in VISN 1 is very high. In 1997, the JCAHO conducted triennial surveys at all VA Medical Centers in VISN 1. The JCAHO is a nationally recognized healthcare accrediting body that surveys most hospitals throughout the country. Their standards and survey results are considered to be the benchmarks for the healthcare industry and are accepted as indicators of the quality of care provided by those institutions it surveys. In VISN 1, all nine VA Medical Centers received three-year accreditation with scores that exceeded the national average for private sector hospitals. In addition, each VA Medical Center in VISN 1 demonstrated improvement in its score from the previous survey and the Providence and VA Connecticut facilities received "Accreditation with Commendation". This is an honor bestowed on very few hospitals and is

indicative of excellent care and conformance to high quality structure and process standards. Several other VISN 1 facilities came close to receiving accreditation with commendation as well. We are currently in the midst of preparing for another survey in which the JCAHO will evaluate us as a Network. This is a pilot program in VHA and we are one of only two VISNs selected to participate in the JCAHO process.

Aside from the technical and clinical measures of quality care, patient satisfaction is an important indicator of the quality of care being provided. The timeliness of service and patients' satisfaction with the care they receive is measured nationally through patient satisfaction surveys.

Entry into the VA system of care begins with the establishment of eligibility. This process often requires completion of a Compensation and Pension examination. The national standard for processing such requests for C&P exams is 35 days. VISN 1 is currently exceeding this standard by completing these exams within 28 days on average. In addition, 98.9% of the exams we conduct are determined to be sufficient to meet the needs of the reviewers. This exceeds the VA standard of 98% and is very close to the exceptional level of performance, which is 99%. In fact, only two of seven Medical Centers that provide these exams in VISN 1 are below the 99% level.

As a VISN, we have been very successful in improving our ability to provide prosthetic devices to eligible veterans in a timely fashion as well. In FY 1998 for

the first three quarters only 0.6% of all orders were delayed by more than five days. The VA standard calls for less than 2% delayed orders. Other measures of timeliness related to the issuance of prosthetic devices are monitored as well. Average Appointment Waiting Times for several clinics that specifically serve veterans who may be in need of prosthetic appliances are monitored nationally. In four of the five clinics, waiting times in VISN 1 are significantly less than the national average waiting times. In the fifth clinic our average waiting time is less than one day longer than the national average.

With regard to patient satisfaction, we are very proud of our performance as measured by patient surveys conducted at the national level on a random sample of outpatients. For the past two years, VISN 1 has received excellent scores in the six categories that are measured: Access, Preferences, Education, Emotional Support, Coordination, and Courtesy. In fact, our scores in each category and our overall score exceed the VA national averages by more than two standard deviations. We are at the top of all VISNs in the area of patient satisfaction based on these results.

In order to maintain the level of achievement we have experienced to date, we must continue the various activities we have described above. We must also supplement existing programs with new initiatives that will enhance quality of care throughout the VISN. Some of the initiatives that have already been developed include the following:

- Hired a full-time physician to serve as the Quality Management Officer for VISN 1.
- Reorganized the performance improvement efforts into a Quality Management Improvement Council (QMIC) with representation from all Medical Centers.
- Developed a model Patient Safety Policy and a Patient Safety Handbook.
- Established standardized practices for incident reporting, which have been adopted as a national model.
- Instituted continuous monitoring of the performance levels of all facilities and required the formation of action plans where necessary to correct deficiencies or improve performance.
- Implemented service lines to ensure the provision of comparable, high quality clinical care and support services throughout the Network.

We believe the establishment of the VISNs has clearly been beneficial to the assurance of quality care throughout the VA. The collaboration and cooperation inherent in the VISN organizational structure provide obvious channels for a broad-based approach to maintaining and enhancing quality across the system. These same benefits are also evident in the area of operations. The VISN concept fosters cooperation and can impose consistent standards of performance among all elements of the integrated system. The operational and strategic changes that have evolved with the implementation of the VISN reorganization have begun to break down some of the previous obstacles to

effective cooperation among VA Medical Centers. Increased collaboration and interaction among all facilities are being encouraged and a new sense of belonging to a system of care is slowly emerging.

As you know, however, these operational and programmatic changes have been accompanied by a change in the way VHA allocates available resources. This has proven to be a complicating factor in VISN 1. In addition to the organizational restructuring and the shift to an integrated healthcare system we have also had to respond to the implementation of the Veterans Equitable Resource Allocation System (VERA). Under this allocation methodology, VISN 1 has experienced a reduction of $52 million dollars in our budget during the last eighteen months. Some individuals and groups have tried to tie the operational and programmatic changes described above to the reduction in the budget. While there can be no doubt that a decrease of $52 million dollars is significant, it did not drive the changes that have been made.

In FY 1996, each VISN produced its first Strategic Plan. This was prior to the development and implementation of VERA, which did not occur until mid-way through FY 1997. In VISN 1's first Strategic Plan, we outlined several strategies for enhancing the quality and accessibility of care across the Network. We described several initiatives that were designed to facilitate the shift from inpatient to outpatient, from the "old VA" to the "new VA". These plans provided a blueprint for the VISN to prepare us to move into the next century as a viable,

modern, state-of-the-art, integrated healthcare system. One of the main objectives was to construct an integrated healthcare delivery system that would use available resources in the most effective and cost efficient manner possible to enable us to provide the most care to the most veterans. Reducing inefficiencies, eliminating redundancies, and combining administrative functions have allowed us to redirect savings to patient care activities.

The strategies contained in this first plan positioned the VISN such that we were able to absorb the reductions associated with the VERA methodology without resorting to eliminating programs or services. We were already decreasing our operating costs through the initiatives outlined in the Strategic Plan. Programs were being streamlined and improved. There were shifts in focus from inpatient to outpatient programs based on clinical evaluations and the goal of enhancing quality and access for veterans. Administrative consolidations were developed and cooperation among facilities was encouraged. The second Strategic Plan provided an update to the initial plan and continued the basic strategies that were developed. There was not a cause and effect connection between VERA budget cuts and our operational or programmatic changes.

Any time an organization undergoes dramatic changes there are likely to be challenges and obstacles encountered along the road to the final objective that has been identified. Change does not come without some discomfort. The VA is no exception. While we have worked diligently to effect a smooth transition in

VISN 1 there have been some rough spots along the way. We have taken substantial precautions to minimize any disruption to any patient's care. Unfortunately, some veterans have attributed any problems they have experienced to the establishment of the VISN and/or to the implementation of VERA and the resultant decrease in available resources in VISN 1.

The shift from a hospital system to a healthcare system has changed how we deliver care to veterans. This includes shorter lengths of stay as an inpatient, fewer admissions to inpatient care, more ambulatory surgery, increased emphasis on wellness and preventive care, the establishment of primary care teams, and a managed care approach along the continuum of care. For many individuals these are new concepts that produce anxiety about the availability and quality of the care they feel they will receive. In spite of efforts to educate everyone about the need for change and the advantages of the proposed plans, some individuals remain skeptical and resistant. We have attempted to address the concerns expressed by such individuals as they have arisen but some of our efforts have not always been well received. There are still some veterans and even some employees who want to go back to the "old VA". This cannot, and should not happen. The shift to outpatient care and the implementation of a managed care, primary care model are significant improvements to the care delivery system for veterans. Those who have given this new approach a chance are generally pleased with these changes. We believe, in time, all

veterans and employees will recognize and understand the benefits of the "new VA".

The organizational and cultural changes inherent in such a dramatic reorganization will require several years to achieve and will require significant adjustments on the part of employees and veterans. Our focus during this process, however, is on ensuring that quality of care is maintained throughout VISN 1. As Dr. Kizer said, "In the 'new VA,' patients will get the right care at the right time in the right place at the right cost." This is our goal 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.

Mr. SHAYS. Thank you, Doctor. At this time I would call on Mr. Gilman if he would like to just make a statement.

Mr. GILMAN. I have some notes coming down, if I could delay until you finish with the panel.

Mr. SHAYS. OK, we'll be happy to do that.

Mr. GILMAN. Thank you, Mr. Chairman.

Mr. SHAYS. Sure. Ms. DeLauro, great to have you here. This is—while you're taking care of that—in our hearing up in New York, we started the hearing, and I started out by saying let me just make—it was very crowded—and I said, Let me just make it very clear. I will adjourn this hearing at a moment's notice if we do not have order. There is to be no cat calling. There is to be no response from the audience. This is—and then the transcriber wrote in, "A chorus of boos." It took about 5 minutes to gain order in that hearing. [Laughter.]

So, Mr. Allen, thank you very much for requesting this hearing be in Washington because I noticed from a memo that there were some punches thrown up in Maine.

Ms. DeLauro.

Ms. DELAURO. Thank you very much, Mr. Chairman. I'd like to say thank you to you, and to Ranking Member Towns and the members of the subcommittee for allowing me to be here today. And I wanted to welcome the entire panel, and particularly say, "Hello," to Vincent Ng, who was, until most recently, the director of the VA Connecticut health care system.

I think it has probably been said by other members of the subcommittee here, we do know that we—that our Nation—owes veterans a tremendous debt, the people who have set aside their time, their efforts, often people who have lost their lives in the defense of this country, need, in fact, to make sure that the freedom and opportunity that they have protected would, in fact, not resound to their benefits as well in the process that we undertake when we are in a peacetime effort. And I think that the VA health service system is one of the most significant means by which we in fact do try to pay back the enormous debt that we owe our veterans. The VA hospitals have helped men and women come to terms and triumph over physical pain, mental scars of what war is about.

I'm not going to sit before you here today and pretend that the VA health service system is perfect. In fact, our VA hospitals, especially in my State of Connecticut, need our help. I think our veterans must be guaranteed quality health care. They need to be assured that the care will be affordable, and they need to have this care in the most efficient way.

VERA, the Veterans' Equitable Resource Allocation system has been touted as a means of providing our veterans with equal access to health care and as an incentive to the regional networks throughout this country to manage their workload and operations efficiently. In 1995, our veterans patiently endured the hardships that VA Connecticut went through. As the very first division of Veterans' Integrated Services Network One, or VISN–1, to integrate the facilities to increase out-patient care and efficiency, the very goals that VERA was aiming to do and accomplish nationwide.

I will be honest with you, I find it troubling that the national VA did not integrate before VA medical centers in Boston, at the same

rate as the Connecticut facilities, to ensure that limited funds are put to the most effective use. For 3 years, VA Connecticut subsidized the inefficiencies of the national VA's handling of the Boston VA facility, draining essential resources from Connecticut facilities. Last year alone, VA Connecticut had a shortfall of approximately $2 million. At the same time, VA Connecticut increased the number of veterans it served from 29,903 in 1995 to 31,963 in 1997, while the number of patients served by the Boston VA facilities actually dropped slightly.

In June of this year, the national VA took a step in the right direction toward improving the quality and efficiency of the health care for all of New England's veterans when it approved the consolidation of in-patient services in the Boston VA facilities at the West Roxbury campus. It's essential in my view that the VA take the next step and ensure that this consolidation results in a more equal allocation of resources within VISN–1.

In July, Congressman Shays and the rest of the Connecticut delegation joined me to send letters to Secretary West, to Dr. FitzGerald expressing our deep concerns about this issue. We also raised this issue at a meeting at the VA Connecticut West Haven campus in my district several months ago. And I must be honest with you, and tell you that our concerns have not been put to rest.

All veterans must receive the same high quality of care that they sacrificed so much for. If we truly want to achieve the goals, let's do it. Let's take steps toward a more equal distribution of resources within the New England network.

I look forward to working with the VA on this issue, as we start to protect the health and well-being of our veterans. I thank you all for being here, and I thank the chairman and the ranking member for allowing me to speak this morning.

[Followup questions and responses follow:]

THE HON. ROSA L. DeLAURO
QUESTIONS FOR THE RECORD
GOVERNMENT REFORM AND OVERSIGHT SUBCOMMITTEE
ON HUMAN RESOURCES
FRIDAY, SEPTEMBER 25, 1998

Service Lines

Service Lines for Ambulatory Care, Mental Health, and Geriatrics are to be instituted in VISN 1 on October 1, 1998.

According to the Memorandum of Understanding for Service Lines in VISN 1 (agreed to by the Department of Veterans Affairs, VISN 1, the National Veterans Affairs Council, and the American Federation of Government Employees), the parties agreed that the stake holders will be pre-decisionally involved in the local design and implementation of local Service Lines and in the development of local Service Lines contracts.

Question: Please provide a status report on the involvement of all of the stake holders in the local design and implementation of Service Lines. Please include meeting minutes, list of attendees, and strategies developed.

Nursing

In the Connecticut Health Care System (CHCS), two issues involving nurses have developed:

- The pay rate of the nurses has been frozen since 1996.
- Severe understaffing of nurses in the psychiatry ward at the New Haven facility resulted in the temporary closing of fifty percent of the beds until approximately November 1998.

Questions:

- Is the shortage in the nursing staff a result of recruiting? If not, what is the cause of the shortage?
- Is the freeze on the rate of pay that nurses are receiving a result of the budget reduction experienced at CHCS?

Aging Population

According to the Strategic Plan FY 1998-FY 2002, resources must be redirected to serve the aging population and the VA must transfer from its "bricks and mortar" approach and build these services. A February 1998 GAO report states that CHCS told the Committee that more nursing homes were available to the veterans.

Question: Please report where these facilities are located, specifically in CHCS. What is their capacity? What is the increase in homes from 1997 to 1998?

Budget

Dr. Kizer told the Connecticut delegation on July 13, 1998, that the FY 1998 reserve of $55 million would be released to the 22 VISNs (see attached table).

Question: Please provide VISN 1's share and how it will be dispersed.

At the same July 13 meeting, Dr. Kizer stated that each VISN subsequently held two percent of its allocation in reserve.

Question: Please provide a summary of how much VISN held in reserve using this formula for FY 1997 and FY 1998 and how it was dispersed throughout the nine facilities of the VISN?

The VISN Allocation Methodology for the Boston Area Hospitals uses one formula while the other facilities use a different formula (see attached figure).

Question: Please explain why there is a different formula used for the different facilities within VISN 1.

STUART FRASER

VISN Allocation Methodology

- Boston Area Hospitals - Took the difference of FY 98 Operational Needs (line B) less Baseline Vera Allocation (line C) Multiplied by 20% then subtracted the Tactical Initiatives (line d) to come up with adjustment. Took Adjustment and subtracted that from the FY 98 Operational Needs (line B)

VISN Allocation Methodology

- For the remaining Divisions, Took FY 97 Allocation (line A) subtracted Tactical Initiatives (line D).

	Additional FY98 Supplemental ($55 million) Dollars in thousands	
Network	Difference between 11/97 and 7/98 Allocation w/o CAPS	Percentage difference between 11/97 and 7/98 Allocation w/o CAPS
Boston	$2,750	0.34
Albany	$1,495	0.37
Bronx	$3,060	0.34
Pittsburgh	$2,880	0.37
[illegible]more	$1,618	0.35
[illegible]am	$2,652	0.38
Atlanta	$3,332	0.38
Bay Pines	$4,155	0.39
Nashville	$2,596	0.37
Cincinnati	$1,963	0.37
Ann Arbor	$2,321	0.37
Chicago	$2,728	0.35
Minneapolis	$1,503	0.36
Omaha	$998	0.36
Kansas City	$2,307	0.37
Jackson	$4,553	0.37
Dallas	$2,493	0.38
Phoenix	$2,195	0.38
Denver	$1,427	0.36
Portland	$2,437	0.36
San Francisco	$2,415	0.33
Long Beach	$3,120	0.33
VHA Totals	$55,000	0.36

DEPARTMENT OF VETERANS AFFAIRS
PRINCIPAL DEPUTY ASSISTANT SECRETARY FOR CONGRESSIONAL AFFAIRS
WASHINGTON DC 20420

November 9, 1998

The Honorable Christopher Shays
Chairman, Subcommittee on Human Resources
Committee on Government Reform and Oversight
U.S. House of Representatives
Washington, DC 20515-6143

Dear Mr. Chairman:

Enclosed are the responses to post-hearing questions you submitted on behalf of Representative Rosa DeLauro in your letter of October 6, 1998, to Dr. Denis FitzGerald, Network Director, VISN 1.

If we can be of further assistance, please contact me or Deborah Bittinger at 202-273-5628.

Sincerely,

Sheila Clarke McCready

Sheila Clarke McCready

Enclosure
SCM/rlh

Post-Hearing Questions
Concerning the September 25, 1998, Hearing

for
Denis J. FitzGerald, MD, MHA
Department of Veterans Affairs

from
Congresswoman Rosa DeLauro
Provided by Congressman Christopher Shays
Chairman, Subcommittee on Human Resources
House Committee on Government Reform and Oversight

1. Services Lines

Service Lines for Ambulatory Care, Mental Health, and Geriatrics are to be instituted in VISN 1 on October 1, 1998.

According to the Memorandum of Understanding for Service Lines in VISN 1 (agreed to by the Department of Veterans Affairs, VISN 1, the National Veterans Affairs Council, and the American Federation of Government Employees), the parties agreed that the stake holders will be pre-decisionally involved in the local design and implementation of local Service Lines and in the development of local Service Lines contracts.

Please provide a status report on the involvement of all the stakeholders in the local design and implementation of Service Lines. Please include meeting minutes, list of attendees, and strategies developed.

Response: At the VA Connecticut Health Care System (VACHS), the only Network service line not in operation at the time the Memorandum of Understanding (MOU) was signed on May 21, 1998, by the Network Director and the American Federation of Government Employees (AFGE), was the Ambulatory Care Service Line at the West Haven campus. A Design Team for this line was commissioned on June 26, 1998, and included members of AFGE. The commissioning memorandum, a representative sample of minutes, and the final recommendations are attached. AFGE is still actively involved with the final implementation steps. The Ambulatory Care Service Line at the Newington campus experienced a smooth transition with the National Association of Government Employees (NAGE) and was used as a model for the rest of the network for ambulatory care. All other Network service lines had been operational at the local level for many months before the MOU was signed. Both Mental Health and Geriatrics at VACHS have functioned as "service lines" for a number of years prior to the implementation of Network service lines.

Service Line contracts are still under development at the Network level. Those contracts, which are under negotiation with the facility Director, have also been shared with AFGE and NAGE.

2. Nursing

In the Connecticut Health Care System (CHCS), two issues involving nurses have developed:

- **The pay rate of the nurses has been frozen since 1996.**
- **Severe understaffing of nurses in the psychiatry ward at the New Haven facility resulted in the temporary closing of fifty percent of the beds until approximately November 1998.**

Is the shortage in the nursing staff a result of recruiting? If not, what is the cause of the shortage?

Response: Management's analysis of the costs per pro-rated patient for psychiatric care showed that VACHS is significantly higher than Network and national averages for almost all diagnostic related groups (DRGs) in both basic and special care categories. Based on this information, decisions were made to defer or delay hiring and to cover the vacancies by shifting nurses away from areas with a higher rate of staffing. This was successful until VACHS experienced a series of unanticipated losses in nursing. Although there is no shortage of candidates, the recruiting and credentialling process can be lengthy and can result in delays in hiring. The combination of these circumstances resulted in the temporary shortage of nurses that required a temporary closing of 15 beds. During October, VACHS recruited two staff nurses for this ward and was able to re-open five beds on October 26. VACHS expects to be able to recruit additional nurses in the near future and currently anticipates re-opening the additional beds by the end of December 1998.

Is the freeze on the rate of pay that nurses are receiving a result of the budget reduction experienced at VACHS?

Response: Pay raises for nurses were not influenced by budget reductions. Nursing pay raises are based on wage surveys conducted annually in our Local Labor Market Area as required by Public Law 101-366. VACHS has remained competitive in wages compared to the local area since 1996. In 1998, although still competitive, salaries for nurses are now in the lower range of the scale. There has been very little increase in pay of nurses in the private sector, and it is believed that hospitals have elected to give bonuses in lieu of pay raises. A new wage survey that will help determine if there is need for pay raises for nurses in FY 99 is currently underway. The Veterans Health Administration (VHA) is currently reviewing issues that have been raised concerning the

locality-based pay system and plans to provide the results of the review and recommendations to the House and Senate Veterans' Affairs Committees by early next year.

3. Aging Population

According to the Strategic Plan FY 1998-FY 2002, resources must be redirected to serve the aging population and the VA must transfer from its "bricks and mortar" approach and build these services. A February 1998 GAO report states that CHCS told the Committee that more nursing homes were available to the veterans.

Please report where these facilities (nursing homes) are located, specifically in CHCS. What is their capacity? What is the increase in homes from 1997 to 1998?

Response: VACHS has developed several new contracts with community nursing homes to provide care for veterans leaving our facility for a more appropriate level of care. Since 1996, contracts have been developed with four new homes in the Naugatuck Valley/Waterbury area including Glendale Nursing Center, Waterbury Convalescent Center, and Mariner Health Care (each with 120 beds). Also during that period we initiated a contract in Durham, CT with Twin Maple Healthcare (total bed capacity of 44).

We are currently in the process of seeking new Nursing Home Care contracts with facilities on the Connecticut shoreline and are in negotiations with Branford Hills (total bed capacity of 189) and St. Joseph's Manor in Trumble (total bed capacity of 210). To date, we have been able to develop community placement options that are sufficient to meet the placement needs of our veterans.

Also, in FY 97, we developed contracts with Hebrew Home in the Newington/ Hartford area, and with Greentree Manor to provide Hospice Care for eligible veterans.

4. Budget

Dr. Kizer told the Connecticut delegation on July 13, 1998, that the FY 1998 reserve of $55 million would be released to the 22 VISNs (see attached table).

Please provide VISN 1's share and how it will be dispersed.

Response: VISN 1's share of the $55 million in reserve funds released by Dr. Kizer amounted to $2,750,000. This money was added to the Network reserves. Network reserves were used to fund approved VISN initiatives and to supplement facility operational needs.

At the same July 13 meeting, Dr. Kizer stated that each VISN subsequently held two percent of its allocation in reserve.

Please provide a summary of how much VISN held in reserve using this formula for FY 1997 and FY 1998 and how it was dispersed throughout the nine facilities of the VISN?

Response: The 2% Network reserve requirement articulated by Dr. Kizer began with the FY 98 allocation process. As you already know, the VISN 1 base for FY 1998 was $770,863,000. A 2% reserve would equate to $15,417,000. The actual reserve maintained by the VISN was $19,309,000. The attached chart shows the initial base funding allocations to each VISN 1 facility for the past three years, the total reserve initially held, and the final allocations that incorporate reserve funding adjustments for each facility.

The VISN Allocation Methodology for the Boston Area Hospitals uses one formula while the other facilities use a different formula (see attached figure).

Please explain why there is a different formula used for the different facilities within VISN 1.

Response: A different formula was used for the Boston area hospitals in order to effect a greater reduction in their budgets. As you can see from the attached charts, the Boston area hospitals lost considerably more money than the remaining hospitals in the VISN.

Attachment 1 to Question 1 - Commissioning Memo

Department of Veterans Affairs

Memorandum

Date: JUN 2 6 1998

From: Acting Director (00)

Subj: Ambulatory Care Service Line Design Team

To: Associate Director For Patient Care Services (001P)

1. This memorandum is for the purpose of establishing a Design Team for the Ambulatory Care Service Line at the West Haven campus. As part of the eight (8) mandatory service lines, the Ambulatory Care service line must be implemented by the end of this fiscal year. Ambulatory Care is currently of greatest importance since this is our core activity, both now and into the future. Our immediate attention needs to be on operationalizing this service line to provide the service benefits outlined by Alice Savage, M.D., Network Service Line Manager For Ambulatory Care. To this end, I am requesting that you Chair this committee to develop an implementation plan and timeline that meets the network criteria for establishing this service line. Team members will include:

Elizabeth Rogers, M.D., Local Service Line Manager, Amb. Care – W. Haven
David Coleman, M.D., Chief, Medical Service
Ronnie Rosenthal, M.D., Chief, Surgical Service
Kenneth Cohen, M.D., Director, Managed Care
Paul Mulinski, Ph.D., Asst. Chief of Staff
Barbara Hendrix, R.N., Assoc. Chief, Nursing Service/OP
Cheryl Korman, Director, Customer Service
Bernadette Oulten, R.N., Chief, Hospital Education Service
Fran Evers, R.N., Utilization Management
AFGE Representative
Sue Kancil

Resource Support:
Juliet Vilinskas, M.D., Local Service Line Manager, Amb. Care – Newt.
David Cornwall, Executive Assistant/Director

2. Attached to this memorandum are resource documents (1/28 "Service Lines", 3/26 "Strategic Planning Committee Minutes", 3/30 "Workforce Analysis: Use Rates and Staffing Models", and the Ambulatory Care Service Line Presentation) that will assist you in developing this implementation plan. I am requesting that you provide me with a draft action plan and timeline by July 10, 1998. Thank you in advance for serving on this design team.

PAUL J. McCOOL

Attachments

cc. 111GM, 111, 112, 11C, 11B, 118, 00/CS, 118A, 11Q, AFGE

VA FORM 2105

Attachment 2 to Question 1 - Final Recommendations

Department of
Veterans Affairs

Memorandum

Date: October 13, 1998

From: Acting Director, VA Connecticut Healthcare System/00

Subj: Subject: Design Team Recommendations

To: Members of Ambulatory Care Service Line Design Team

1. I want to thank you all for the tremendous effort you put into the development of the recommendations for the structure of the Ambulatory Care Service Line. The recommendations were comprehensive and inclusive and reflect an extremely thoughtful process. I also want to thank you for completing the planning of this important structure within the short time frame .

2. I have reviewed the recommendations and have approved the majority of them. I request that you have further discussion on recommendation #32, sections b and c. The recommendations need to be further clarified. I also would like to defer action on recommendation #14 until the 1999 Management Retreat. This is an excellent recommendation but will require joint problem solving by the administrative and clinical leaders in a forum such as the retreat. Recommendation #15 must be deferred for action to the Network Service Line Manager and the Division Director. With regard to recommendation #16, I have approved membership on all the listed committees with the exception of the Governing Board and the Resource Committee.

3. Again, thank you for your outstanding efforts.

PAUL J. McCOOL

Ambulatory Care Service Line Design Team Recommendations

RECOMMENDATION	WHO	APPROVE/DISAPPROVE COMMENTS	TARGET DATE
1. The Ambulatory Care Service Line have the following defined Mission and Vision Statement: (see attachment). This mission and vision be shared with all staff at the West Haven Campus.	Director, Associate Directors, Chief of Staff, Service Chiefs		Completed by Sept. 15, 1998
. The Ambulatory Care Service Line will consist of the following: a. Primary Care Programs based in General Internal Medicine, Medical sub-specialties and Neurology. Primary Care delivered in Geriatrics and Psychiatry will not be included in this service line. b. Ancillary and support staff integral to those Primary Care Programs c. Support staff to the sub-specialty medical and surgical clinics d. Community Based Outpatient Clinics e. Specific categories of staff to be assigned to the Ambulatory Care Service Line include: Primary Care Providers (MD's, PA's/NP's) Ancillary staff (RN's, NA's, PCA's, social workers, Clinical pharmacists, clinical dieticians, health psychology, clinical dieticians), Support (Clerks)	Director's approval Union approval VISN Director approval	Approved	August 15, 1998
3. A draft listing by FTEE and name of staff who will be assigned to the service line be developed and sent to Dr. Savage, VISN Ambulatory Care Service Line Manager.	Dr. Rogers	Approved	Completed
4. Primary Care delivered in Psychiatry should be part of the Mental Health Service Line and Geriatrics Primary Care delivered in Geriatrics and HBPC should be part of the Extended Care Line. The Psychiatric Emergency Room should be part of the Mental Health Service Line. The Mental health and Geriatric Service Line Manager will be responsible for assuring that the quality of primary care in these service lines is comparable to that of the Ambulatory Care Service Line.	Director Approval	Approved	October 1, 1998
5. The APU and ER should be incorporated into the Acute Care Service Line. It is expected that the ER will continue to do some triage, however the Design Team supports the ongoing process of transfer of staffing from the ER to Primary Care as the use of the ER for other than emergent care continues to decrease.	Director Approval Dr. Rogers and Dr. Cohen to facilitate the movement of FTEE from the Triage area to the Ambulatory Service Line	Approved	August 15, 1998 Ongoing
6. Evaluate resources and work to establish a third firm in the Ambulatory Care Service Line.	Director Approval, Dr Rogers	Approved	October 1, 1998

Attachment 3 to Question 1 - Minutes

Revised 7-9-98

Ambulatory Service Line Design Team Meeting
July 7, 1998
CIO Conference Room

Present: Coleman, Rogers, Cohen, Wright, Lustman, Veazey, Hendrix, Kancir, Mulinski, Oulton

The following items were discussed:

1. The committee reviewed the agenda, suggested discussion items prepared by Mrs. Veazey. (See attached)

2. The committee discussed the development of the structure for the Ambulatory Care Service Line and the need to modify the structure used in the ambulatory care pilot projects because of this facility's large research and education mission. It was agreed that Service Lines are a way of reaching a goal, not just a goal themselves. Certain core components of the VISN guidelines must be incorporated.

3. The group suggested that the following items be added to the agenda: developing and maintaining staff competency, education and training, and support line for the medical/surgical sub-specialty clinics.

4. The committee discussed primary care delivered in the psychiatric and geriatric services. It was agreed that the standards for primary care must be the same, no matter where primary care is delivered.

5. At third FIRM needs to be established as there are still around 10,000 patients at the West Haven Campus that do not have a primary Provider.

RECOMMENDATIONS:

1. The Ambulatory Care Service Line will consist of the following:
   a. Primary Care Programs based in General Internal Medicine, Medical Sub-specialties excluding Geriatrics and Neurology.
   b. Ancillary and support staff integral to those Primary Care Programs
   c. Support staff to the sub-specialty medical and surgical clinics
   d. CBC's
   e. Specific categories of staff to be assigned to the Ambulatory Care Service Line include:
      PCP Providers (MD's, PA's/NP's)
      Ancillary staff (RN's, NA's, PCA's, social workers, clinical pharmacists, clinical dieticians, health psychology, clinical dieticians)
      Support (Clerks)

2. Psych Primary Care should be part of the Mental Health Service Line and Geriatrics Primary Care including HBPC should be part of the Geriatric Service Line. Psych ER should be part of the Mental Health Service Line.

3. The APU and ER should be incorporated into the Acute Care Service Line. It is expected that the ER will continue to do some triage, however the Team supports the ongoing process of transfer of staffing from the ER to Primary Care as the use of the ER for urgent rather than emergent care continues to decrease. The committee also recommends that the structures of the APU and OR be evaluated including a review and implementation of the 1995 CQI report on the APU.

The committee also recommends that the structures of the APU and OR be evaluated including a review and continuing implementation of the 1995 CQI report on the APU. Systems of the APU must be reviewed, streamlined and made more efficient.

4. Evaluate resources and work to establish a third FIRM in the Ambulatory Care Service Line.

AGENDA
AMBULATORY SERVICE LINE DESIGN TEAM
JULY 7, 1998

1. STRUCTURE OF VA CONNECTICUT AMBULATORY CARE SERVICE LINE

   a. REVIEW OF GUIDELINES—HOW DO THEY APPLY HERE? DEFINE OUR STRUCTURE HERE

   b. RELATIONSHIP OF LOCAL SERVICE LINE MANAGER TO THE BED SERVICE CHIEFS

   c. SERVICE LINE MANAGER'S ROLE IN VA CONNECTICUT GOVERNENCE—WHAT COMMITTEES IS HE/SHE A MEMBER?

   d. SERVICE LINE MANAGER'S RELATIONSHIP TO THE AFFILIATION

   e. RESEARCH COMPONENT OF THE AMBULATORY CARE SERVICE LINE

   f. HOW DOES EDUCATION OF HOUSESTAFF/MEDICAL STUDENTS FIT INTO THE SERVICE LINE CONCEPT?

   g. RELATIONSHIP TO OTHER SERVICES—i.e. NURSING/MAS/SOCIAL WORK/ DIETETICS/PHARMACY

   h. WHERE DOES THE EMERGENCY ROOM FIT IN?

   i. DO WE PHASE OUT THE TRIAGE AREA/FUNCTION?

   j. WHERE DOES PSYCH PRIMARY CARE FIT IN—HOW TO KEEP TO THE SAME STANDARDS IF SEPARATE?

2. QUALITY ISSUES

   a. ALREADY MEASURES DEFINED TO EVALUATE EFFECTIVENESS

   b. SHOULD THERE BE LOCAL MEASURES TO MONITOR SUCH ISSUES AS FLOW OF CARE ACROSS THE CONTINUUM/IDENTIFY LOCAL, UNIQUE SYSTEMS ISSUES THAT MAY INTERFERE WITH THE DELIVERY OF CARE ACROSS THE LINES?

3. TIMELINE FOR IMPLEMENTATION

   a. MUST BE DONE BY SEPT 30

   b. WHO, WHAT, WHERE, WHEN

4. RELATIONSHIP OF SUBSPECIALITIES WITH AMBULATORY CARE SERVICE LINE

a. CONTRACTUAL RELATIONSHIP VS EVENTUAL INTEGRATION INTO A SUB-SPECIALITY GROUP PRACTICE—WHICH ONE WOULD BE INTEGRATED VS. STAYING SEPARATE?

b. HOW DO WE CONTINUE THE MOVEMENT FROM SUBSPECIALITY CARE TO PRIMARY CARE?

c. CONSULTATIONS—TIME STANDARDS FOR RESPONSE

d. DOES COST OF CONSULTATION COME OUT OF THE AMBULATORY CARE SERVICE LINE BUDGET?

e. SUBSPECIALISTS THAT PROVIDE PRIMARY CARE—WHO DO THEY REPORT TO IN THE SERVICE LINE?

5. RELATIONSHIP OF AMBULATORY CARE SERVICE LINE WITH OTHER COMPONENTS OF THE HEALTHCARE SYSTEM

a. HOW SERVICES ARE OBTAINED FROM GERIATRICS/MENTAL HEALTH/ACUTE CARE HOME CARE?

b. WHO MANAGES THE INPATIENT EPISODE OF CARE? ROLE OF THE PRIMARY PROVIDER

c. HOW TO RESOLVE DIFFERENCES BETWEEN THE COMPONENTS

d. HOW TO INSURE CONTINUM OF CARE ACROSS THE COMPONENTS?

e. WHAT, IF ANY, HEATHCARE POLICIES WILL BE AFFECTED BY THE SERVICE LINE.

6. INTEGRATION OF THE SERVICE LINE WITH MEDICAL CENTER ACTIVITIES

a. HOW DOES THE INFORMATION FROM THE NETWORK AMBULATORY SERVICE LINE COMMITTEES (QUALITY IMPROVEMENT, CLINICAL PRACTICE, STRATEGIC PLANNING, INFORMATION MANAGEMENT, AND POLICY COMMITTEE) BECOME INTEGRATED WITH LOCAL COMMITTEE LEVEL ACTIVITIES?

b. HOW DO WE MAINTAIN ONE STANDARD OF CARE ACROSS THE DIFFERENT SERVICE LINES/COMPONENTS OF VA CONNECTICUT–FOR JCAHO ACCREDIATION/CARF ACCREDIATION?

c. WILL THERE BE SHARING OF RESOURCES IF ONE AREA IS EXPERIENCING RECRUITMENT DIFFICULTIES? i.e.. MANY VACANCIES IN CLERKS?

d. HOW DOES THE SERVICE LINE CONTRIBUTE TO OUR MISSION OF DOD BACK UP

Ambulatory Service Line Design Team Meeting
July 8, 1998
CIO Conference Room

Present: Coleman, Rogers, Cohen, Wright, Veazey, Oulton, Hendrix, Kancir, Mulinski

1. A revised Agenda was distributed (attachment).

2. The minutes of the July 7, 1998 meeting were amended and approved with the changes.

3. There was extensive discussion of the relationship the medical sub-specialists to the Ambulatory Care Service Line. No sub-specialist is doing primary care full time. How will these individuals be supervised when their function crosses over the ambulatory care service line and other service lines? The following two options were discussed:

OPTION 1: The total amount of time that sub-specialists spend doing primary care would be added to and show up in the cost of the Ambulatory Care Service Line. The sub-specialists delivering primary care part of their time would be held accountable to the standards of primary care as defined by the VISN, such as CDI/PI, evaluative measures such as panel size (based on proportion of FTEE spent in primary care, utilization of services per unique social security number, etc.) for the patients for which they are primary providers. They would be accountable to the Chief of Medicine for their sub-specialty practice. As part of their salary would be paid by the Ambulatory Care Service Line, they would also be accountable to the Ambulatory Care Service Line Manager for the primary care part of their practice. The Ambulatory Care Service Line Manager would work closely with the Chief of Medicine in managing the sub-specialists involved in primary care and would participate in their performance evaluations.

OPTION 2: The Ambulatory Care Service Line Manager would contract from the Chief of Medicine for the primary care services of sub-specialists and provide funding for a set number of FTEE of sub-specialists that would provide primary care. The supervision of the sub-specialists would remain totally with the Chief of Medicine.

Additional discussion on issues such as QM tracking, panel size, case mix was addressed. In either option 1 or 2, the panel size for primary care would be 800-1000 patients per FTEE. The primary provider will be available to the patient 20 hours per week and the patient would be seen urgently at other times as part of the group. Attendings would be available to see patients when fellows were not available.

RECOMMENDATION: The committee recommends that option 1 be adopted.

4. The Committee discussed the mechanism for credentialing and privileging of primary care providers (physicians, NP'S, PA'S).

RECCOMENDATION: That all primary care providers be credentialed and privileged by the Medical Staff Executive Committee. The Ambulatory Care Service Line Manager would sign off with the Chief of Medicine on the recommendation that the practitioner be privileged and what the specific privileges would be delineated for each individual Practitioner.

5. A discussion of the role of Quality Management in the Service Line was completed.

RECOMMENDATION: The Quality Management Staff assigned to the Ambulatory Care Service Line be matrixed to the Ambulatory Care Service Line Manager.

6. The relationship of the women's Clinic to the Ambulatory Care Service Line was discussed.

RECOMMENDATION: The Women's Clinic will be considered a part of the Ambulatory Care Service Line.

7. The role of the present Ambulatory Care Council was discussed.

RECOMMENDATION: The current Ambulatory Care Council be discontinued and a new council be formed under the Chairmanship of the Ambulatory Care Service Line Manager. This council would be called the Ambulatory Care Service Line Council.

8. The relationship to the Ambulatory Care Service Line to Compensation and Pension functions and Employee Health was discussed.

RECOMMENDATION: That Compensation and Pension functions and Employee Health not be a part of the Ambulatory Care Service Line. These functions should be centralized under one individual.

9. A discussion of the role of rehabilitative services to the Ambulatory Care Service Line was discussed . It was decided to defer this discussion until a future meeting. Dr. Mulinski will obtain a chart of the rehabilitation staff functions and assignments to aid in the discussion..

10. The role of medical education and research in the Ambulatory Care Service Line was discussed.

RECOMMENDATION: The mission of the Ambulatory Care Service Line at VA CT. includes clinical care, medical education and research. Dr. Rogers will develop a mission statement for the Ambulatory Care Service Line that contains all three of these components. FTEE allocations for the Ambulatory Care Service Line must include resources to meet all three of these components of the mission.

11. The group discussed the relationship/accountability of support services such as Human Resources, Facilities Management Service, and IRM to the Ambulatory Care Service Line. There were strong opinions that there must be mechanisms for strict, defined accountability of those services to meet the needs of the Ambulatory Care and other service lines.

RECOMMENDATION: The accountability and responsiveness to the needs of the Ambulatory Care Service Line by the support services such as Human Resources, Facilities Management, and IRM be clearly defined and that this accountability be clearly defined in the performance standards of the Chief's of those services and in also in the performance measures of the Associate Directors. The AEB must be restructured to include the Ambulatory Care Service Line Manager and future service line managers as members. The focus of the AEB meetings must be changed to include joint problem solving and monitoring of the support/responsiveness of the administrative services to the service lines.

12. A discussion was held regarding the internal support needed by the Ambulatory Care Service Line Manager to administer the service line.

RECOMMENDATION: Adequate support must be provided to the Service Line Managers office in the form of FTEE to insure appropriate data management, supervision and clerical support. There must be an assistant service line manager /AO appointed.

Ambulatory Care Service Line Design Team Meeting
July 9, 1998
Nursing Conference Room

Present: Veazey, Rogers, Hendrix, Reynolds, Mulinski, Kancir, Cohen, Oulton

1. Ron Reynolds, AFGE representative distributed the Memorandum of Understanding and discussed the document.

2. The committee discussed the role of the Ambulatory Care Service Line Manager in the governance of VA. CT.

RECOMMENDATION: The Ambulatory Care Service Line Manger be a member of the following healthcare system committees/groups.

Medical Staff Executive Committee (if the service line manager is not a physician, the highest ranking physician in the service line is a member.)
Governing Body
Strategic Planning
AEB
Resources Committee (or the group that makes resource decisions)
Clinical Operations
Morning Report
Acute Care Council
CQI Council
Clinical Bed Services
Information Management
Partnership Council

3. Discussion was held on the relationship of the Ambulatory Care Service Line Manager to the affiliation.

RECOMMENDATION: The group recommends that the role of the Chief of Staff be maintained and the Chief of Staff be the liaison with the affiliation on broad issues. The bed service chief's must continue their academic roles. The Ambulatory Care Service Line manager will have an academic appointment. He/she will collaborate with the Chief of Staff on affiliation issues and will participate in the Dean's Committee (or other appropriate groups formed with the affiliation). The Ambulatory Care Service Line Manager will represent the VA to the affiliation with regard to issues related to ambulatory care.

4. A preliminary discussion was held on what amount of support time should be given for non-career development researchers in the Ambulatory Care Service Line. Dr. Wright will meet with Dr. Rogers and report back to the committee with recommendations. The discussion on the relationship of the ambulatory Care Service Line Manager and the Bed Service Chiefs was deferred until Dr. Rosenthal and Dr. Coleman are present.

Ambulatory Service Line Design Team Meeting
July 14, 1998
CIO Conference Room

Present: Rogers, Cohen, Wright, Veazey, Oulton, Hendrix, Kancir, Mulinski, Reynolds, Korman

1. The minutes of the July 7, 8 and 9, 1998 meetings were amended and approved with the changes.

2. Discussion on the relationship of the local Ambulatory Care Service Line Manager to the bed service chiefs was again deferred until Dr. Rosenthal can attend the meeting.

3. Discussion on the research component of the Ambulatory Care Service Line was deferred until Dr. Rogers and Dr. Wright can meet.

4. A discussion was held on the role of the Ambulatory Care Service line staff in relation to medical education.

RECOMMENDATION: The VA commitment to medical education in primary care requires that primary care providers participate in the training of housestaff, medical students and students from Associate Health disciplines who rotate through Primary Care. Further, this commitment recognizes the activity involved in this education and provides for the time it involves.

5. A discussion was held on quality and performance improvement issues related to the Ambulatory Care Service Line.

RECOMMENDATION: The Ambulatory Care Service Line will monitor those activities prescribed by the VISN and Headquarters including provider specific profiling with relation to utilization issues, CDI/PI. Other areas to be monitored will be patient satisfaction, timeliness of consultation, clinical pertinence, and clinical outcomes. The establishment of this service line will change our patient care delivery system we use presently for the delivery of primary care to a new system that is hypothesized to improve patient care, outcomes of care, patient satisfaction, access and allow for more efficient utilization of resources. Using the PDCA method, evaluative measures and baseline data will be established prior to the implementation of the service line. At prescribed intervals after implementation, data will be collected on the evaluative measures to measure and do an analysis of the effectiveness of the system changes and appropriate changes instituted. By October 1, 1998, a performance improvement plan will be in place and baseline monitors and data identified with timelines for monitoring and evaluation. Responsible individuals will be Sue Kancir, Dr. Rogers, and Cheryl Korman.

6. The group recommended that the following topic is added to the master agenda under number 5, f., Employee Education.

7. Dr. Mulinski presented a document that showed the current deployment of Rehabilitative Medicine personnel. Dr. Rogers will meet with Dr. Drickimer to discuss the feasibility of having some of this staff assigned to the Ambulatory Care Service Line. Dr. Rogers will report back to this group in two weeks.

8. A discussion was held on how the Ambulatory Care Service Line will contract with the Medical and Surgical Services for sub-specialty care.

a. The next discussion related to how to continue the movement of patients from sub-specialty care to primary care. There are still patients going to sub-specialty clinics that could be discharged from those clinics and enrolled in primary care. These individuals may not be receiving primary care.

RECOMMENDATION: Continue the process that was used to discharge patients who had received maximum benefit from the orthopedic clinic. This involved a concurrent review by a nurse practitioner and the physicians. Included in this process will be patient education on the new way care is being organized and the definition and advantages of primary care. Patients that are discharged from the sub-speciality clinics will be assigned a primary provider.

9. Defer action on Agenda item 3: Timeline for Implementation.

10. Dr. Mulinski distributed an OT/PT handout that had been discussed in Extended Care Council. The committee agreed that they need input from Dr. Drickamer on staffing support/accountability and costing.

11. There was a discussion on contracting for sub-specialty service. Dr. Rogers and the group reviewed several options on payment for support. A discussion on how outside HMO's cost out payments was held as well as the best way to contract our, i.e., actual procedures or block contracts.

RECOMMENDATION: Ambulatory Care will contract out for sub-specialty support and then Ambulatory Care Service Line Manager will determine how to distribute that support.

12. Discussions were held on how to figure in the cost of teaching/research into the contracting cost. One option presented was for the COS to receive a sum for the hospital and then distribute it throughout the service lines. Further discussion is needed to determine an outcome.

a. Currently we don't have accurate costs for services; most costs are based on historical data. Until guidelines come from the VISN we will do contracts based on our established costs.

RECOMMENDATION: Contracts will be done when information systems are in place and VISN mandated. Costs included will depend on quality and access of care.

13. QM is working on a system to determine when a patient should go from specialty care to Primary Care. Jill Edwards is reviewing clinics and moving inappropriate patients to primary care. Once all clinics have been reviewed and timeframe for future review will be determined. When the new Education Center is established the change over of patients from specialty to Primary Care should be easier.

RECOMMENDATION: Continue to have QM review clinics; establish reviews on at least every 1 ½ years; if a patient want a specialty clinic appointment it must be scheduled through a Primary Care Physician.

Ambulatory Care Service Line Design Team Minutes
July 24, 1998

Present: Rogers, Coleman, Wright, Veazey, Kancir, Reynolds, Hendrix

I. Discussion and recommendations:

1. RECOMMENDATION: All information from the Network Ambulatory Care Service Line Committees (Quality Improvement, Clinical Practice, Strategic Planning, Information Management and Policy Committee) be reviewed in the Ambulatory Care Council and appropriate information be forwarded to the MSEC and AEB to the Governing Board. Discussion of appropriate items from Network Level Ambulatory Care Service Line Committees should be a standing agenda item of the Ambulatory Care Council.

2. RECOMMENDATION: At the time the other service lines are established, the committee structure of VA Connecticut Healthcare System should be evaluated/modified to insure the appropriate flow of information for performance improvement and continuity across the facility.

3. RECOMMENDATION: The Chief of Staff and Nurse Executive monitor the distribution of resources across the service lines during times of recruitment difficulties or shortages of staff due to extended leaves and facilitate sharing between service lines to insure cost effective care.

4. RECOMMENDATION: The Bed Service Chiefs and the Ambulatory Care Service Line Manager will relate to each other in a collaborative, matrixed relationship.

II. At the next meeting a discussion will be held on the system for performance evaluation.

ail message for NEDOSKO,ANDREA K SECRETARY
rinted at WEST-HAVEN.VA.GOV 16 Oct 98 09:46
ubj: Amb Care Design Team [#9300661] 21 Jul 98 10:12 2 Lines
rom: NEDOSKO,ANDREA K in 'AmbCare' basket. Page 1

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he meeting tentatively scheduled for Wednesday July 22 at 11:00am is
anceled. A new date and time will be set up for later this week.

ocal Message-ID: 9300661@WEST-HAVEN.VA.GOV (21 Recipients)
> 21 RECIPIENTS ! <<

<<< This message was ADDRESSED as follows ! >>>

BATAYO,ALAN D
VERY,MICHELE C.
ASTELLON,ELIZABETH F
OHEN,KENNETH L
OLEMAN,DAVID L.
ORNWALL,DAVID L
VERS,FRANCES A.
ART,JOANNE
ENDRIX,BARBARA H.
ANCIR,SUE B
ORMAN,CHERYL A
ISCHKE,KURT
ULINSKI,PAUL
EDOSKO,ANDREA K
ULTON,BERNADETTE R.
EYNOLDS,RONALD W.
OGERS,ELIZABETH L
OSENTHAL,RONNIE A.
ARNADO,RALPH J
EAZEY,MARGARET
ILINSKAS,JULIET

Ambulatory Service Line Design Team Meeting
July 21, 1998
Director Conference Room

Present: Cohen, Veazey, Mulinski, Reynolds

1. The minutes of the July 14, 1998 meeting and the list of recommendations were amended and approved with the following changes:
Recommendations:
a. 7-7-98, #3. Delete last sentence
b. 7-8-98, #5, Add Primary Care component of Women's Clinic will etc.; #6 include membership will include the Union.
c. 7-14-98, #4, Add, Union does not want to wave its right to negotiate, #6, delete original and add QM/Nurse Practitioner will review specialty clinics to discharge inappropriate patients and to assign them to a Primary Care Provider, patients with Primary Care Providers who want a specialty clinic appointment need to be scheduled through their Primary Care Provider or the Emergency Department; establish a review system for every year to year and a half.

2. Agenda Items
5.a A lengthy discussion was held on the most appropriate way to provide Geriatric/Mental Health/Acute Care Home Care service. This discussion also included the difficult tracking system for payment and additional FTEE that would be needed. The group felt that these types of services should be contracted for just like other sub-specialty areas. There might be an option to negotiate at the VISN level on the structure of the Service levels.

RECOMMENDATION: Wait for further discussion and policy development from the VISN before establishing internal guidelines.

5.b. Episode of care:

RECOMMENDATION: The Acute Care Line attending manages episodes of care and works with the Primary Care Provider.

5c. Resolution of differences:

RECOMMENDATION: If difference between acute and primary care providers can be resolved the issues would be brought to the Service Line manager. If an additional decision is needed the issue would be brought to the Chief of Staff for final resolution.

5d. Continuum of Care

RECOMMENDATION: Follow the policy currently being developed by the VISN. Use that policy to develop an individual hospital-wide policy that complies.

5e. Policies

RECOMMEDNATION; Designate someone to review all current hospital polices and update them to comply with VISN service line changes.

6b. Standard of care
RECOMMEDATION: Once the VISN establishes standardized policies all hospitals in the VISN 1 will be in compliance.

6c. Defer to Dr. Rogers

Attachment

West Haven Campus
950 Campbell Avenue
West Haven, CT 06516

Commercial Phone: 203-937-3888
FTS Phone: 700-428-3888
Commercial Fax: 203-937-3868
FTS Fax 700-428-3868

Newington Campus
555 Willard Avenue
Newington, CT 06111

Commercial Number 860-667-6785
FTS Phone 700-643-6785
Commercial Fax 860-667-6764
FTS Fax 700-643-6764

DIRECTOR'S OFFICE

Paul J. McCool, Acting Director/00
Karen Waghorn, Associate Director/001
Margaret Veazey, R.N., Associate Director/001p
Fred S. Wright, M.D., Acting Chief of Staff

FAX COVER SHEET

Date: 8-3-98

To: Amb. Care Design Team members

Location:

Fax Number:

From: M. Veazey

Pages to Follow: 4

Comments: Please add, correct or amend as needed & return by Friday Aug 7, 1998

CONFIDENTIALITY NOTE

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Ambulatory Care Service Line Design Team Recommendations

RECOMMENDATION	WHO	TARGET DATE
1. The Ambulatory Care Service Line have the following defined Mission and Vision Statement: (see attachment). This mission and vision be shared with all staff at the West Haven Campus.	Director, Associate Directors, Chief of Staff, Service Chiefs	Completed by Sept. 15, 1998
2. The Ambulatory Care Service Line will consist of the following: a. Primary Care Programs based in General Internal Medicine, Medical sub-specialties and Neurology. Primary Care delivered in Geriatrics and Psychiatry will not be included in this service line. b. Ancillary and support staff integral to those Primary Care Programs c. Support staff to the sub-specialty medical and surgical clinics d. Community Based Outpatient Clinics e. Specific categories of staff to be assigned to the Ambulatory Care Service Line include: Primary Care Providers (MD's, PA's/NP's) Ancillary staff (RN's, NA's, PCA's, social workers, Clinical pharmacists, clinical dieticians, health psychology, clinical dieticians), Support (Clerks)	Director's approval Union approval VISN Director approval	August 15, 1998
3. A draft listing by FTEE and name of staff who will be assigned to the service line be developed and sent to Dr. Savage, VISN Ambulatory Care Service Line Manager.	Dr. Rogers	Completed
4. Primary Care delivered in Psychiatry should be part of the Mental Health Service Line and Geriatrics Primary Care delivered in Geriatrics and HBPC should be part of the Extended Care Line. The Psychiatric Emergency Room should be part of the Mental Health Service Line. The Mental health and Geriatric Service Line Manager will be responsible for assuring that the quality of primary care in these service lines is comparable to that of the Ambulatory Care Service Line.	Director Approval	October 1, 1998
5. The APU and ER should be incorporated into the Acute Care Service Line. It is expected that the ER will continue to do some triage, however the Design Team supports the ongoing process of transfer of staffing from the ER to Primary Care as the use of the ER for other than emergent care continues to decrease.	Director Approval Dr. Rogers and Dr. Cohen to facilitate the movement of FTEE from the Triage area to the Ambulatory Service Line	August 15, 1998 Ongoing
6. Evaluate resources and work to establish a third firm in the Ambulatory Care Service Line.	Director Approval, Dr Rogers	October 1, 1998
7. The total amount of time that sub-specialists spend doing primary care would be added to and show up in the cost of the Ambulatory Care Service Line. The sub-specialists delivering primary care part of their time would be held accountable to the standards of primary care as defined by the VISN, such as CDHPI, evaluative measures such as panel size (based on proportion of FTEE spent in primary care, utilization of services per unique social security number, etc.), access and patient satisfaction for the patients for which they are primary providers. They would be accountable to the Chief of Medicine for their sub-specialty practice. As part of their salary would be paid by the Ambulatory Care Service Line, they would also be accountable to the Ambulatory Care Service Line Manager for the primary care part of their practice. The Ambulatory Care Service Line Manager will work closely with the Chief of Medicine in managing the sub-specialists involved in primary care and would participate in their performance evaluations.	Director Approval. Dr. Rogers and Dr. Coleman to develop systems/policies	October 1, 1998

8. All primary care providers will be credentialed and privileged by the Medical Staff Executive Committee. The Ambulatory Care Service Line Manager will offer concurrence with the chief of service on practitioner privileges which occur in the Ambulatory Care area. The Ambulatory Care Service Line Manager will also sign off the primary care component of the privileges of individuals delivering primary care in any service line. Specific criteria for designation as a Primary Care Provider are enclosed.	Director Approval COS and Credentialing Office to develop policy/procedures/systems	October 1, 1998
9. Quality Management Service will collaborate with the Ambulatory Care Service Line related to performance improvement activities. Staff should function in a matrixed fashion.	Director Approval	October 1, 1998
10. The Primary Care component of the Women's Clinic and staff support to the Women's Clinic will be considered a part of the Ambulatory Care Service Line.	Director Approval	October 1, 1998
11. The current Ambulatory Care Council be discontinued and a new council be formed under the Chairmanship of the Ambulatory Care Service Line Manager. This council would be called the Ambulatory Care Service Line Council. Membership will include the following: 1) Ambulatory Care Service Line Manager 2) Chief of Staff 3) Director, Emergency Room 4) Chief of Medicine 5) Chief of Surgery 6) Chief of Neurology 7) Mental Health Service Line Manager 8) Nurse Executive 9) Associate Director 10) Hospital Education 11) Quality Management 12) Union Representative/AFGE 13) Extended Care Service Line Manager 14) Acute Care Service Line Manager	Director Approval Policy Development by Dr. Rogers First meeting	August 15, 1998 August 30, 1998 September 15, 1998
12. The Compensation and Pension functions and Employee Health should not be a part of the Ambulatory Care Service Line	Director Approval	August 15, 1998
13. The mission of the Ambulatory Care Service Line at VACHS. Includes clinical care, medical education and research. The mission statement for the Ambulatory Care Service Line will contain all three of these components. FTEE allocations for the Ambulatory Care Service Line will include resources to meet all three of these components of the mission.	Director Approval Dr. Rogers has completed draft of mission—staffing draft completed	August 15, 1998
14. The accountability and responsiveness to the needs of the Ambulatory Care Service Line by the support services such as Human Resources, Facilities Management, and IRM be clearly defined and delineated in the performance standards of the Chief's of those services and in also in the performance measures of the Associate Directors. The AEB should be restructured to include the Ambulatory Care Service Line Manager and future service line managers as members, including AFGE. The focus of the AEB meetings should be changed to include joint problem solving and monitoring of the support/responsiveness of the administrative services to the service lines.	Director Approval Associate Directors to restructure AEB—develop new policy on the committee	August 15, 1998 October 1, 1998

5. Adequate support must be provided to the Service Line Managers office in the form of FTEE to insure appropriate data management, supervision and clerical support. There must be an assistant service line manager /AO appointed.	Director Approval Dr Rogers to select A/O	August 15, 1998 October 1, 1998
6. The Ambulatory Care Service Line Manger is a member of the following healthcare system committees/groups: 1) Medical Staff Executive Committee (if the service line manager is not a physician, the highest-ranking physician in the service line is a member.) 2) Governing Body 3) Strategic Planning 4) AGB 5) Resources Committee (or the group that makes resource decisions) 6) Clinical Operations 7) Morning Report 8) Acute Care Council 9) CQI Council 10) Clinical Bed Services 11) Information Management 12) Partnership Council	Director Approval New committee policies developed by QM	August 15, 1998 October 1, 1998
17. The role of the Chief of Staff is maintained and the Chief of Staff be the liaison with the affiliation on broad issues. The clinical chief's must continue their academic roles. The Ambulatory Care Service Line manager should be eligible for an academic appointment. He/she will collaborate with the Chief of Staff on affiliation issues and will participate in the Dean's Committee (or other appropriate groups formed with the medical school. The Ambulatory Care Service Line Manager, along with the Chief of Staff and appropriate Bed Service Chiefs will represent the VA to the medical school with regard to issues related to ambulatory care.	Director Approval COS to communicate the model to the affiliation	August 15, 1998 September 1, 1998
18. The VA commitment to medical education in primary care requires that primary care providers participate in the training of housestaff, medical students and students from Associate Health disciplines who rotate through Primary Care. In addition, the desirability for development of educational tools and scholarly activities related to primary care, as well as the need for development of continuing education and retraining of health professionals in Primary Care is affirmed. Further, this commitment recognizes the activity involved in this education and provides for the time it involves.	Director Approval	August 15, 1998
19. The Ambulatory Care Service Line will monitor those activities prescribed by the VISN and Headquarters including provider specific profiling with relation to utilization issues, CDI/PI. Other areas to be monitored will be patient satisfaction, timeliness of consultation, clinical pertinence, and clinical outcomes. The establishment of this service line will change our patient care delivery system we use presently for the delivery of primary care to a new system that is hypothesized to improve patient care, outcomes of care, patient satisfaction, access and allow for more efficient utilization of resources. Using the Plan-Do-Check-Act method, evaluative measures and baseline data will be established prior to the implementation of the service line. At prescribed intervals after implementation, data will be collected on the evaluative measures to measure and do an analysis of the effectiveness of the system changes and appropriate changes instituted. A performance improvement plan will be in place and baseline monitors and data identified with timelines for monitoring and evaluation.	Director Approval Dr. Rogers, Sue Kancir and Cheryl Kornnan to develop plan	August 15, 1998 October 1, 1998

0. Continue the process of discharging patients who have received maximum benefit from specialty linics as appropriate. Referral to specialty clinics should be through the primary care provider. Exceptions ıay be made for Women's Clinic.	Director Approval Dr. Rogers	August 15, 1998 Ongoing
1. Ambulatory Care will contract for sub-specialty services. It is expected that most contracting will ccur within the resources/services of VACHS	Director Approval Dr. Rogers and Bed Service Chiefs	August 1, 1998 Date to be determined
2. Contracts will be done when information systems are in place and VISN mandated. Costs included ·ill depend on quality and access of care.	Director Approval	Date to be determined
3. The union does not waive its right to negotiate on any of these items at a future time.	Director Concurrence	Ongoing
4. An education program will be established for medical center staff on the design, structure and operation f the Ambulatory Care Service Line. This educational program should be completed by October 1, 1998. nformational bulletins should appear regularly in Good Morning VA Connecticut.	Director Approval Hospital Education AFGE and Public Relations	August 15, 1998 September 15, 1998
5. An education Program will be planned for stakeholders and the Ambulatory Care Service Line should ·e described in the next patient newsletter.	Director Approval Public Relations	August 15, 1998 September 15, 1998
6. All information from the Network Ambulatory Care Service Line Committees (Quality Improvement, Clinical Practice, Strategic Planning, Information Management and Policy Committee) be reviewed in the ambulatory Care Council and appropriate information be forwarded to the MSEC, AEB and the Governing Board. Discussion of appropriate items from Network level Ambulatory Care Service Line Committees hould be a standing agenda item of the Ambulatory Care Council.	Director Approval QM to develop reporting mechanisms	August 15, 1998 October 1, 1998
7. At the time the other service lines are established, the committee structure of VA Connecticut Healthcare System should be evaluated/modified to insure the appropriate flow of information for ·erformance improvement and continuity across the facility	Director Approval	Date to be determined
8. The Chief of Staff, Nurse Executive, Associate Directors monitor the distribution of resources among he service lines during times of recruitment difficulties or shortages of staff due to extended leaves and acilitates sharing between service lines.	Director Approval COS and Nurse Executive	August 15, 1998 Ongoing
9. The Clinical Service Chiefs and Ambulatory Care Service Line Manager will relate to each other in a ollaborative, matrixed relationship	Director Approval Dr. Rogers and Bed Service Chiefs	August 15, 1998 Ongoing
0. Hospital Education Service will collaborate with the Ambulatory Care Service Line related to .nployee education activities.	Chief, Hospital Education	Ongoing
1. Customer Service will collaborate with Ambulatory Care Service Line related to activities to :ontinually improve customer service.	Chief, Customer Service	Ongoing
2. Performance Appraisals/Proficiencies for . Bargaining unit employees will be signed off per union contract. . RN's annual proficiency report will be completed by the firm Chief with input from firm RN, and jointly ·igned off by the RN Executive and the local Service Line Manager.	Dr. Rogers and HRMS	Ongoing
3. Relevant Health System Policies will be revised as necessary to be concurrent with Ambulatory Care Service lines.	Directors approval QM and Dr. Rogers	Ongoing

7. The total amount of time that sub-specialists spend doing primary care would be added to and show up in the cost of the Ambulatory Care Service Line. The sub-specialists delivering primary care part of their time would be held accountable to the standards of primary care as defined by the VISN, such as CDHP, evaluative measures such as panel size (based on proportion of FTEE spent in primary care, utilization of services per unique social security number, etc.), access and patient satisfaction for the patients for which they are primary providers. They would be accountable to the Chief of Medicine for their sub-specialty practice. As part of their salary would be paid by the Ambulatory Care Service Line, they would also be accountable to the Ambulatory Care Service Line Manager for the primary care part of their practice. The Ambulatory Care Service Line Manager will work closely with the Chief of Medicine in managing the sub-specialists involved in primary care and would participate in their performance evaluations.	Director Approval. Dr. Rogers and Dr. Coleman to develop systems/policies	Approval	October 1, 1998
8. All primary care providers will be credentialed and privileged by the Medical Staff Executive Committee. The Ambulatory Care Service Line Manager will offer concurrence with the chief of service on practitioner privileges which occur in the Ambulatory Care area. The Ambulatory Care Service Line Manager will also sign off the primary care component of the privileges of individuals delivering primary care in any service line. Specific criteria for designation as a Primary Care Provider are enclosed.	Director Approval COS and Credentialing Office to develop policy/procedures/systems	Approval	October 1, 1998
9. Quality Management Service will collaborate with the Ambulatory Care Service Line related to performance improvement activities. Staff should function in a matrixed fashion.	Director Approval	Approval	October 1, 1998
10. The Primary Care component of the Women's Clinic and staff support to the Women's Clinic will be considered a part of the Ambulatory Care Service Line.	Director Approval	Approval	October 1, 1998
11. The current Ambulatory Care Council be discontinued and a new council be formed under the Chairmanship of the Ambulatory Care Service Line Manager. This council would be called the Ambulatory Care Service Line Council. Membership will include the following: 1) Ambulatory Care Service Line Manager 2) Chief of Staff 3) Director, Emergency Room 4) Chief of Medicine 5) Chief of Surgery 6) Chief of Neurology 7) Mental Health Service Line Manager 8) Nurse Executive 9) Associate Director 10) Hospital Education 11) Quality Management 12) Union Representative/AFGE 13) Extended Care Service Line Manager 14) Acute Care Service Line Manager	Director Approval Policy Development by Dr. Rogers First meeting	Approval	August 15, 1998 August 30, 1998 September 15, 1998
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13. The mission of the Ambulatory Care Service Line at VACHS. includes clinical care, medical education and research. The mission statement for the Ambulatory Care Service Line will contain all three of these components. FTEE allocations for the Ambulatory Care Service Line will include resources to meet all three of these components of the mission.	Director Approval Dr. Rogers has completed draft of mission—staffing draft completed	Approved	August 15, 1998
14. The accountability and responsiveness to the needs of the Ambulatory Care Service Line by the support services such as Human Resources, Facilities Management, and RM be clearly defined and delineated in the performance standards of the Chief's of those services and in also in the performance measures of the Associate Directors. The AEB should be restructured to include the Ambulatory Care Service Line Manager and future service line managers as members, including AFGE. The focus of the AEB meetings should be changed to include joint problem solving and monitoring of the support/responsiveness of the administrative services to the service lines.	Director Approval Associate Directors to restructure AEB-- develop new policy on the committee	Date for joint problem solving at 1999 Retreat.	August 15, 1998 October 1, 1998
15. Adequate support must be provided to the Service Line Managers office in the form of FTEE to insure appropriate data management, supervision and clerical support. There must be an assistant service line manager /AO appointed.	Director Approval Dr Rogers to select A/O	Date for picking of Assistant and Fin Mgmt Director	August 15, 1998 October 1, 1998
16. The Ambulatory Care Service Line Manger is a member of the following healthcare system committees/groups: 1) Medical Staff Executive Committee (if the service line manager is not a physician, the highest-ranking physician in the service line is a member.) 2) Governing Body 3) Strategic Planning 4) AEB 5) Resources Committee (or the group that makes resource decisions) 6) Clinical Operations 7) Morning Report 8) Acute Care Council 9) CQI Council 10) Clinical Bed Services 11) Information Management 12) Partnership Council	Director Approval New committee policies developed by QM	Approved with following exceptions: Governing Body, Executive Committee	August 15, 1998 October 1, 1998
17. The role of the Chief of Staff is maintained and the Chief of Staff be the liaison with the affiliation on broad issues. The clinical chief's must continue their academic roles. The Ambulatory Care Service Line manager should be eligible for an academic appointment. He/she will collaborate with the Chief of Staff on affiliation issues and will participate in the Dean's Committee (or other appropriate groups formed with the medical school. The Ambulatory Care Service Line Manager, along with the Chief of Staff and appropriate Bed Service Chiefs will represent the VA to the medical school with regard to issues related to ambulatory care.	Director Approval COS to communicate the model to the affiliation	Approved	August 15, 1998 September 1, 1998

18. The VA commitment to medical education in primary care requires that primary care providers participate in the training of housestaff, medical students and students from Associate Health disciplines who rotate through Primary Care. In addition, the desirability for development of educational tools and scholarly activities related to primary care, as well as the need for development of continuing education and retraining of health professionals in Primary Care is affirmed. Further, this commitment recognizes the activity involved in this education and provides for the time it involves.	Director Approval	Approval	August 15, 1998
19. The Ambulatory Care Service Line will monitor those activities prescribed by the VISN and Headquarters including provider specific profiling with relation to utilization issues, CDI/PI. Other areas to be monitored will be patient satisfaction, timeliness of consultation, clinical pertinence, and clinical outcomes. The establishment of this service line will change our patient care delivery system we use presently for the delivery of primary care to a new system that is hypothesized to improve patient care, outcomes of care, patient satisfaction, access and allow for more efficient utilization of resources. Using the Plan-Do-Check-Act method, evaluative measures and baseline data will be established prior to the implementation of the service line. At prescribed intervals after implementation, data will be collected on the evaluative measures to measure and do an analysis of the effectiveness of the system changes and appropriate changes instituted. A performance improvement plan will be in place and baseline monitors and data identified with timelines for monitoring and evaluation.	Director Approval Dr. Rogers, Sue Kaucir and Cheryl Korman to develop plan	Approval	August 15, 1998 October 1, 1998
20. Continue the process of discharging patients who have received maximum benefit from specialty clinics as appropriate. Referral to specialty clinics should be through the primary care provider. Exceptions may be made for Women's Clinic.	Director Approval Dr. Rogers	Approval	August 15, 1998 Ongoing
21. Ambulatory Care will contract for sub-specialty services. It is expected that most contracting will occur within the resources/services of VACHS	Director Approval Dr. Rogers and Hed Service Chiefs	Approval	August 1, 1998 Date to be determined
22. Contracts will be done when information systems are in place and VISN mandated. Costs included will depend on quality and access of care.	Director Approval	Approval	Date to be determined
23. The union does not waive its right to negotiate on any of these items at a future time.	Director Concurrence	Approval	Ongoing
24. An education program will be established for medical center staff on the design, structure and operation of the Ambulatory Care Service Line. This educational program should be completed by October 1, 1998. Informational bulletins should appear regularly in Good Morning VA Connecticut.	Director Approval Hospital Education APOE and Public Relations	Approval	August 15, 1998 September 15, 1998
25. An education Program will be planned for stakeholders and the Ambulatory Care Service Line should be described in the next patient newsletter.	Director Approval Public Relations	Approval	August 15, 1998 September 15, 1998
26. All information from the Network Ambulatory Care Service Line Committees (Quality Improvement, Clinical Practice, Strategic Planning, Information Management and Policy Committee) be reviewed in the Ambulatory Care Council and appropriate information be forwarded to the MSEC, AEB and the Governing Board. Discussion of appropriate items from Network level Ambulatory Care Service Line Committees should be a standing agenda item of the Ambulatory Care Council.	Director Approval QM to develop reporting mechanisms	Approval	August 15, 1998 October 1, 1998

27. At the time the other service lines are established, the committee structure of VA Connecticut Healthcare System should be evaluated/modified to insure the appropriate flow of information for performance improvement and continuity across the facility	Director Approval	Approval	Date to be determined
28. The Chief of Staff, Nurse Executive, Associate Directors monitor the distribution of resources among the service lines during times of recruitment difficulties or shortages of staff due to extended leaves and facilitates sharing between service lines.	Director Approval COS and Nurse Executive	Approval	August 15, 1998 Ongoing
29 The Clinical Service Chiefs and Ambulatory Care Service Line Manager will relate to each other in a collaborative, matrixed relationship	Director Approval Dr. Rogers and Bed Service Chiefs	Approval	August 15, 1998 Ongoing
30. Hospital Education Service will collaborate with the Ambulatory Care Service Line related to employee education activities.	Chief, Hospital Education	Approval	Ongoing
31. Customer Service will collaborate with Ambulatory Care Service Line related to activities to continually improve customer service.	Chief, Customer Service	Approval	Ongoing
32. Performance Appraisals/Proficiencies for a. Bargaining unit employees will be signed off per union contract. b. RN's annual proficiency report will be completed by the firm Chief with input from firm RN, and jointly signed off by the RN Executive and the local Service Line Manager. c. Physicians with the Ambulatory Care Srv line will have their annual proficiency report completed by the firm Chief and jointly signed off by the Professional Srv Chief and the local Srv Line Manager. Medical Specialist who devote only a small percentage of their time to Primary Care will have their annual proficiency report completed by the Medicine Section Chief, and jointly signed off by the Chief/Medicine and the local Ambulatory Care Srv Line Manager. Neurology, Psychiatry or Geriatric clinicians who practice Primary Care will have their annual proficiency report completed by the appropriate Professional Srv or Section Chief and jointly signed off by the Ambulatory Care Srv Line Manager as well as the appropriate Acute, Mental Health or Geriatric Srv Line manager.	Dr. Rogers, HRMS, Involved Service Chiefs Directors approval	Require further discussion.	a.Ongoing b. Oct 1, 98 c. Oct 1, 98
33. Relevant Health System Policies will be revised as necessary to be concurrent with Ambulatory Care Service lines.	Directors approval QM and Dr. Rogers	Approval	Ongoing

10.8.98

Revised: August 27, 1998

Attachment to Question 4

VA NEW ENGLAND HEALTHCARE SYSTEM
VISN 1 INITIAL FUNDING ALLOCATIONS

Allocation FY 96, 97 & 98	**FY 96 Allocation	FY 97 Allocation	*FY 98 Allocation	% Change
Bedford	79,892	74,436	69,870	-6.1%
Boston	154,041	150,909	139,466	-7.6%
Brockton/West Rox	150,457	141,369	136,274	-3.6%
CHCS	160,060	157,107	157,361	0.2%
Manchester	42,379	41,845	41,975	0.3%
Northampton	53,487	52,771	52,422	-0.7%
Providence	63,820	63,026	62,956	-0.1%
Togus	69,185	68,313	68,759	0.7%
White River Jct.	48,484	47,465	47,753	0.6%
Total:	821,805	797,241	776,836	-2.6%
Network Operations		2,606	2,718	4.3%
Reserves		11,588	19,309	66.6%
Total Available:		811,435	798,863	-1.5%

* Includes MCCF Collections $28 million.
** FY 1996 Allocation by the former Eastern Region of VHA.

FY 1999 Allocations have not been approved and we are currently reviewing various allocation scenarios with the Director of each facility.

Note: These figures do not include specific purpose funding, NRM, Equipment or supplemental funding provided to facilities.

Initial Allocations plus Reserve Funding Adjustments

Allocation FY 96, 97 & 98	**FY 96 Allocation	FY 97 Allocation	*FY 98 Allocation	% Change
Bedford	81,632	77,481	71,088	-8.3%
Boston	155,781	153,954	140,684	-8.6%
Brockton/West Rox	152,197	144,414	137,492	-4.8%
CHCS	162,388	157,805	160,286	1.6%
Manchester	43,455	42,971	45,921	6.9%
Northampton	54,563	53,897	56,368	4.6%
Providence	64,896	64,152	66,902	4.3%
Togus	70,261	69,439	72,705	4.7%
White River Jct.	50,417 **	48,760 ***	50,678 ****	3.9%
Total:	835,590	812,873	802,124	-1.3%

** 15 Million of one time start up money for VISN Operations.

*** Reprogram Equipment and Travel dollars with Headquarters and other VISNs

**** Reprogram Equipment and Travel dollars with Headquarters and other VISNs

Mr. SHAYS. I thank the gentlelady from New Haven, and also say that she is clearly one of the reasons why we're having this hearing, and I should have acknowledged that at the beginning. Thank you.

Mr. Gilman.

Mr. GILMAN. Thank you, Mr. Chairman. My notes haven't arrived yet, but at any rate I first of all want to thank you, Chairman Shays, for conducting this series of hearings. You started off by your willingness to come up to our region where there was a substantial amount of problems.

Mr. SHAYS. Never again. [Laughter.]

Mr. GILMAN. Well, we hope you will come back because no matter—the boos were not against you, they were against the VA system, and they welcomed your being there to provide the oversight. And our VISN–3 New York area had been impacted by the new VERA program that took funding from a very heavily populated northeastern region and shifted it around the country. There were also a number of problems with regard to quality of care, with regard to the loss of specialized services, with regard to an inefficiency in the hospitals. A number of those complaints have been rectified. However, we're still confronted with very serious financial cutbacks, cutbacks that are a result of the VERA program. And I still have a great deal of concern about this new formula of shifting funds from one part of the country to the other part of the country, reducing quality care to our veterans in our heavy populated region. And, of course, the Veterans' Administration states continually that, "Well, we're trying to take care of the move of the population shifts to other parts of the country." That may be, population shifts, but that doesn't take away one iota from the necessity to make certain that every veteran gets quality care on an equitable basis, and that's not happening as a result of this VERA program.

Then we were appalled to hear that the Director, a Regional Director, was receiving a bonus because he was able to reduce costs at the same time when you were reducing funding for the veterans in our area. And that certainly didn't make sense. And now, once again, we're hearing that there's a budget deficit because of a poor budgeting proposal that did not take into account some inflationary costs.

So again we're confronted with a further reduction, compounding the problems that we've had in the past. And I think that the Veterans' Director—and I'm pleased to see that we have so many of our good leaders here, particularly Dr. Garthwaite, our Deputy Under Secretary for health—should take a look at what's happening to the quality of care as a result of the reduction in funding, as a result of the VERA system. I think the VERA system, it's time we revised that system and made certain that funding is not going to be impacted on one region or another because of the need to shift money. This Congress provided more funding for Veterans' Administration health care than prior Congresses. But lo and behold, because of the shift from one place to another, we're suddenly impacted in some regions, such as the Northeast, for no good cause. And I hope that you're going to find a way to resolve that.

I do have, Mr. Chairman, a statement that I would like to submit for the record.

[The prepared statement of Hon. Benjamin Gilman follows:]

By Rep. Gilman
Comm. on Govt Reform

9/25/98

GOOD MORNING. I WOULD LIKE TO EXTEND MY GRATITUDE AND DEEP SENSE OF APPRECIATION TO CHAIRMAN SHAYS FOR HOLDING THIS HEARING ON VETERANS HEALTH CARE IN THE NORTHEAST.

LAST YEAR, CHAIRMAN SHAYS WAS KIND ENOUGH TO HOLD A FIELD HEARING IN MY DISTRICT ON THE EFFECTS VERA WAS HAVING ON VETERANS HEALTH CARE IN NEW YORK. THE RESULTS OF THAT HEARING WERE NOT ENCOURAGING. WE FOUND THAT THE SHIFT IN HEALTH CARE RESOURCES WAS HAVING A NEGATIVE EFFECT ON THE QUALITY OF CARE FOR VETERANS, AND THAT VA PERSONNEL WERE BEING OVERSTRETCHED TO MEET TOO MANY OBLIGATIONS WITH TOO FEW RESOURCES.

IT IS NOW MY UNDERSTANDING THAT THIS SITUATION MAY BE REPEATING ITSELF IN OTHER VA NETWORKS, SPECIFICALLY THAT IN NEW ENGLAND.

I HAVE LONG BELIEVED THE VA'S INITIAL RESPONSE TO CONGRESSIONAL CONCERNS POISONED THE ATMOSPHERE ON THIS SUBJECT. OUR CONCERNS HAVE NOT BEING ADDRESSED ADEQUATELY, AND I FELT THAT CONGRESSIONAL INTERVENTION WAS WARRANTED.

MANY OF YOU HAVE PROBABLY HEARD OF THE PLAN DEVELOPED BY THE VA TO SHIFT FUNDING TO GEOGRAPHIC AREAS THAT HAVE INADEQUATE RESOURCES TO MEET THEIR LEVEL OF DEMAND. THIS PLAN, KNOWN AS THE VETERANS EQUITY RESOURCE ALLOCATION MODEL, HAS RESULTED IN HEALTH CARE FUNDS FLOWING AWAY FROM NEW YORK TO PLACES LIKE ARIZONA AND MISSISSIPPI.

BY NOW, YOU ALL ARE UNDOUBTEDLY AWARE THAT I HAVE MAJOR PHILOSOPHICAL DISAGREEMENTS WITH THE PROPONENTS OF VERA, IN BOTH THE CONGRESS AND THE ADMINISTRATION. I BELIEVE THIS PLAN IS ULTIMATELY HARMFUL TO THE VETERANS OF THE NORTHEAST AND DESPITE ALL ASSURANCES TO THE CONTRARY, WILL RESULT IN A DECREASE IN THE QUALITY OF CARE PROVIDED.

3

THE WATCHWORD FOR VERA IS EFFICIENCY. WHILE I AGREE THAT THERE IS MUCH FAT WITHIN THE VA THAT NEEDS TO BE TRIMMED, I WOULD REMIND YOU THAT EFFICIENCY IS NOT AN UNMITIGATED GOOD. IT IS POSSIBLE TO GO TOO FAR IN SCALING BACK SERVICES.

WE HAVE HEARD MUCH IN THE LAST YEAR ABOUT THE NEED FOR THE VA TO MODEL PRIVATE SECTOR HEALTH CARE. TO A CERTAIN EXTENT THIS IS NEEDED, BUT THE PRIVATE SECTOR EXAMPLE IS NOT A PANACEA TO ALL OF OUR PROBLEMS. MANY OF YOU HAVE HEARD HORROR STORIES ABOUT HMO'S THAT HAVE CUT BACK TOO FAR AND PLACE THE BOTTOM LINE OF PROFITABILITY BEFORE PATIENT CARE. THIS CAN NOT & MUST NOT BE ALLOWED TO HAPPEN TO THE VA.

UNLIKE OTHER SO-CALLED ENTITLEMENTS, VETERANS HEALTH CARE BENEFITS WERE EARNED THROUGH BLOOD AND SACRIFICE. FOR THIS REASON, THE VA HAS A PUBLIC DUTY TO OUR VETERANS AND TO THE AMERICAN TAXPAYER TO DELIVER HEALTH CARE THAT IS EQUAL OR SUPERIOR TO THAT IN THE PRIVATE SECTOR. THE VA IS IN ESSENCE THE STEWARD OF OUR

VETERANS' HEALTH. IN MAINTAINING THIS STEWARDSHIP, THE VA SHOULD NOT REPEAT THE MISTAKES OF THE PRIVATE SECTOR WITH THE STREAMLINING OF HEALTH CARE.

THERE HAS ALSO BEEN THE DISTURBING TREND OF SOME VA OFFICIALS IN WASHINGTON TO CONSISTENTLY ATTEMPT TO SHIFT THE FAULT FOR THIS SITUATION TO CONGRESS, SAYING THAT THE CONGRESS HAS UNDER FUNDED VA HEALTH CARE IN THE PAST. THESE CHARGES HAVE BEEN LEVELED DESPITE THE FACT THAT CONGRESS TRADITIONALLY MEETS THE PRESIDENT'S REQUEST FOR HEALTH -CARE FUNDING.

IN FACT, LAST YEAR, VA OFFICIALS TESTIFIED THAT THEY DID NOT WANT ANY ADDITIONAL FUNDS FOR THIS FISCAL YEAR. THE ADMINISTRATION HAS PROPOSED A FLAT BUDGET UNTIL 2002, WHICH WILL TREAT UP TO 20% MORE VETERANS. THE VA CLAIMS THIS IS POSSIBLE WITHOUT ADDITIONAL FUNDS DUE TO SAVINGS FROM EFFICIENCIES AND RETENTION OF THIRD PARTY REIMBURSEMENTS. THIS REMAINS TO BE SEEN.

WE IN THE CONGRESS HAVE REPEATEDLY STATED THAT WE ARE

WILLING TO WORK WITH THE VA TO ADDRESS THE ONGOING ISSUE OF QUALITY OF CARE. IF MORE FUNDS ARE NEEDED TO ASSURE PROPER CARE, WE NEED TO KNOW. MOREOVER, THOSE OF US IN THE CONGRESS MAY OFTEN HAVE VALUABLE IDEAS WHICH WARRANT EXPERIMENTATION.

IT IS MY HOPE THAT THIS HEARING TODAY WILL SERVE AS THE FIRST STEP TOWARDS IMPROVING THE STRAINED RELATIONSHIP BETWEEN OUR VETERANS AND THE VA.

Mr. SHAYS. We'll submit that, but I think your own statement was probably better.

Mr. GILMAN. Thank you. [Laughter.]

Mr. Chairman, our veterans can't thank you enough for continuing this oversight hearing, and I want to commend Congresswoman DeLauro too for appearing with us. I know that Congresswoman Sue Kelly has been actively involved in my region, and will probably want to submit a statement to your committee. But please continue these oversight hearings. And if it helps one veteran in getting the kind of care that's needed, I think you've done a lot of good.

Thank you, Mr. Chairman.

Mr. SHAYS. Thank you. Mr. Towns said if he's chairman next year, he'll make sure we'll continue.

Let me just recognize, Mr. Towns, but beforehand to just acknowledge, Mr. Ng, that you really did a superb job in Connecticut. You did bring efficiencies, and I think in many cases provided better services. And it was disappointing for us to see that your good work was in a sense misused by the reallocation of funds that should have stayed in the Connecticut system to go to Boston and other areas. I do recognize, as well now, that you're head of network 14 in Omaha, NE, and we're sorry to have lost you.

Mr. Towns.

Mr. TOWNS. Thank you, Mr. Chairman. I listened to the testimony, and you talked about the high quality of care, and I must admit that when you hear that, you're impressed. But when you think about the fact that, if it's not acceptable, what difference does it make? And that's the concern. That's what I'm hearing from people. If you have it, but then they can't get to it, what difference does it make? Can you respond to that?

Dr. GARTHWAITE. I'll be happy to. We share your concern and this transformation that Dr. Kizer and I and others at this table and throughout the Nation have been undertaking over the past 3 years has opened over 200 additional community-based out-patient clinics and have many more in the pipeline. We truly believe that it is inappropriate for people to have to drive long distances for their primary care. We've been able to open significant access points across the Nation. One of the ones that comes to mind is in the Rio Grande Valley, which for years has been a chronic complaint and a chronic source of concern from Congress and from the veterans alike. It's I think, if I remember right, 320 miles from Brownsville, TX to San Antonio. So kind of the same sense of distance you might get in driving from Maine to Boston. And what we've been able to do is strike some local agreements to get primary care and a fair amount of secondary care, and veterans only travel for the things that are worth traveling a great distance for. For their quality and their rareness, is it reasonable to make those trips?

We're looking right now at doing similar sorts of things in Maine. We're taking a hard look at what's possible in terms of contracting. It varies dramatically around the country, what's available in terms of local resources, and the price we can pay and the services and the quality of the services that we can find in the community.

But we're very open to that, and in total agreement that access is a critical piece of quality.

Mr. TOWNS. With the shift in resources demanded by the Veterans' Integrated Service Network, has this also required a shift in personnel? Let me just say why I'm asking this. It is because if you have to get rid of experienced personnel, they don't transfer with you; and then, of course, you've got to now get new people. And I'm trying to get this whole quality thing in my head because it seems to me you get new folks that are inexperienced, and in many instances, will not know what to do; and to me that has a tendency to affect quality. Just here in the Congress, new Members have to take a little while to get into the routine, learn the rules of the House to be able to do the kinds of things that need to be done. And so, therefore, they say seniority is important. So what about in a situation where people refuse to transfer and you have to now hire new folks? Does this affect quality?

Dr. GARTHWAITE. Well, certainly it can. And people are clearly the most important resource, and the most important determinant of quality in a service industry like health care. Most of our changes in terms of places where we've had employees have been to get smaller. We've tried to do that using attrition so that there has been minimal impact on individual employees. Most of the change has been administrative consolidations where we've looked for administrative efficiencies by combining the management structures of nearby facilities. Dr. Ng did that, I think quite well, with a minimum of disruption at Newington and West Haven.

When we go out into a community to startup a community-based out-patient clinic, we will obviously use the best people we can find. That may be transferred employees from other facilities, but it's also likely to be people who live in that community who have the appropriate training in the skills that we need, often primary care, nursing, social work, mental health, and so forth. So I think you're absolutely right. And we try to make all these changes with the work force in mind. And I agree with you.

Mr. TOWNS. And the other one which is, I don't know at what point in time you do your evaluation or your study or you look at numbers in terms of people coming in, talking about veterans coming into a location because I found out that when you take the survey will determine in some part how many patients you have. A lot of patients in the Northeast, if it's the winter and you do it, they might be somewhere else. So I'm wondering, and I look at all this, and I'm sort of trying to figure out, if we're really being fair, because people now get in a trailer and they just drive and they relocate until the winter is over and then they come back. So I'm sort of—do you have any kind of formula in place that will help you be able to make those kind of adjustments?

Dr. GARTHWAITE. We currently correct all our data for what's called a pro-rated patient. That is to say, if a patient gets care in more than one network, we divide the allocation between the networks based on how much care was provided by each one. We don't think that's the most sophisticated or necessarily perfectly accurate method; and we're undertaking a study and trying to understand how we can do that without creating inadvertent incentives for various unintended kinds of health care behaviors. But to a reasonable

degree, at least in my estimation, we do account for the snowbird phenomenon, people that winter in the south.

Mr. TOWNS. Well, I raise that question because let me just be right up front. I'm concerned about the Northeast region and, of course, how it affects New York in particular. So you'll be hearing more from me on this.

Mr. Chairman, with that in mind, I yield back.

Mr. SHAYS. Mr. Gilman, you have the floor, but if you'd like to—Mr. Allen. I'm happy to call on Mr. Allen.

Mr. GILMAN. Yes.

Mr. SHAYS. Mr. Allen, you have the floor.

Mr. ALLEN. I thank the gentleman for yielding. Thank you for being here. This is, as you know, a matter of great significance to veterans in Maine, to the staff and providers at the Togus Hospital, and really to all of you, as well. And I appreciate your being here.

But I do want to say just a couple of things at the outset. The State of Maine is as large as the rest of New England combined. You made, Dr. Garthwaite, a comment about how far it is from Maine to Boston. Well, Portland to Boston is a couple of hours. But I can drive to New York from Portland faster than I can drive to the northern part of Maine, up to the northern border. It's a long way. It's a big State, and so part of the travel problems and problems with appointments made life very difficult for veterans and their families up in Maine.

I have heard from some people that the veterans population is an adverse risk population to a significant extent; and I've heard the number 70 percent. Is that a number that you would agree with, compared to the Medicare population?

Dr. GARTHWAITE. Right. I think by almost any measure our patients tend to be older, poorer, sicker, have more existing diseases. And I think we could give you way more numbers than you probably care to look at to document that. And I think we could argue about a percentage. By any stretch of the imagination, anybody that has ever looked at this, veterans are significantly sicker than the Medicare population and virtually any other population you might look at.

Mr. ALLEN. The reason I raise that is that it's my understanding that if you were to look at what is spent on Medicare and divide that by the number of Medicare recipients, you've got a number, a cost of $5,000 or $6,000. If you look at what we're trying to do with veterans, we're trying to provide a sicker population with a capitated cost of roughly $2,600. How do we do that? Can we do that?

Dr. GARTHWAITE. Well, the $2,600 is for the low-risks pool. We provide $36,000 for the high risk pool. You also need to keep in mind that ours is not a closed system, or closed capitation system. Many of our veterans have additional access to health care, either through insurance that they or their spouses might have, or through Medicare. And there's a fairly significant overlap between dual use of Medicare and the VA. And we're getting our hands around that better than we ever have with newer data systems. So it's not as simple as when your only insurance is a capitated amount and you get all your care through that insurance; and you add up those numbers. It would be relatively simple to understand

the cost of caring for a given population. For veterans, it's I think much more complex. I'll stop there.

Mr. ALLEN. Thank you. This is really for Mr. Sims and perhaps Dr. FitzGerald. What we hear through the delegation all the time is the care at Togus is generally quite good if you can get it, but the waiting times still seem to be an issue, the staffing problems come up over and over again. And I'd really, maybe first to Mr. Sims, can you describe the current staffing situation, particularly with respect to dental services, and other specialized services? What kinds of problems are you facing now? Who has left recently? What kind of gaps are there? And can you describe some of the problems you've had in finding adequate staff in the past?

Mr. SIMS. Thank you very much. I'd be pleased to respond to that, and certainly we continue to recruit in many areas for a number of specialists. As it pertains to dental service, we're pleased to announce that we have a new dentist and a new dental assistant coming on board the first part of October to help us with the workload that we currently encounter in our dental service.

We just have on board within the last month a second cardiologist, a position that we were recruiting for a period of time. We are in the final stages of getting on board a neurologist, another position that we were recruiting for a long period of time, over a year.

I'll just mention that, in fact, I have a recent publication from the Maine Hospital Association, the difficulties that we see in terms of recruiting providers at Togus are not unusual in the State of Maine. They often, the hospitals in Maine, often experience periods of up to 2 years and as many as 4 years for some specialists. So it's a difficult prospect many times.

Our staffing continues to be augmented by changes in how we're providing some of the care in terms of the clinics that we have to provide for timeliness and access. We've recently got new leadership for our primary care teams who are revamping the way our primary care clinics are running. We're instituting case managers to help with the process to make sure that the veterans are seen on a more timely basis, and that all of their concerns are answered appropriately.

Togus, along with the other facilities in VISN–1, has now implemented a telephone care program 24 hours a day, a telephone triage availability so that veterans can call in and thereby save a trip perhaps to Togus or one of the out-based clinics.

So a number of things are being put in place as we continue to look at improvement and efficiency and access.

Mr. ALLEN. Mr. Sims, you would agree with me though that the neurologist, for example, that position was not filled for what, over a year? Or about a year?

Mr. SIMS. The previous incumbent left over a year ago, yes.

Mr. ALLEN. And I will just say this. I know you struggle with the issue, but it's clear to us that the vacancies have led to real significant morale problems on the staff. And I don't know if you have any suggestions on how to deal with those?

Mr. SIMS. Well, we continue to provide coverage in those instances in the most effective way that we can. In many instances, we've brought on board what are known as "locum tenens" physicians, temporary physicians to fill in the gaps. In some instances,

we have had to increase our referrals to the Boston facility for some of that specialized coverage. Again, despite our attempts to try to contract locally for some of these things.

Mr. ALLEN. Can you deal with the pharmacy issue? My understanding is four pharmacists just resigned recently. Can you describe what your understanding was of the reason for the resignation, and what steps you're taking to try to remedy that problem?

Mr. SIMS. Yes, again, we've had a recent turnover, as you point out, four pharmacists have chosen to go back to opportunities in the private sector, citing pay as the reason for that. The pay available in the private sector for pharmacists, particularly in our area, is much higher. Again, in pharmacy we're actively recruiting. We just had a new pharmacist come on board about a week ago. Have another one in the works. And there again, we've brought on a couple of temporary pharmacists to help maintain the workload.

Mr. ALLEN. This I think would be for both Dr. FitzGerald and for Mr. Sims. We've heard over and over again about the difficulties of getting that first appointment, and you've had conversations, Mr. Sims, with me, with Mr. Baldacci, and other members of the delegation. Back in February, it seemed as if that problem—you were making significant progress in that area. Has that progress been maintained? And then for Dr. FitzGerald, is there any comparison among hospitals in VISN–1 about the repetitiveness with which a patient can get an initial appointment or subsequent appointments when they need them? In whatever order you'd like to take them.

Mr. SIMS. Indeed, we continue to work on that issue. We see in our primary care clinics right now an average of 25 to 30 new patients per week, and it is a big issue of trying to make sure that we get those people in on a timely basis for that first appointment. As I mentioned, we have new leadership in our primary care clinics, readjusting the resources we have available there. Dr. LeMay is instituting a process whereby all the physicians in primary care clinics will have four 1-hour slots per week available to them for new appointments, new patients. In addition, those providers who have not been up to the 32 hour per week, in terms of clinic time, will be increasing their clinic time to accommodate those new appointments.

Mr. ALLEN. Do you have some numbers on how long it takes right now to get that first appointment? The goal was to drive it down from 4 to 6 months down to 30 days or less, as I recall.

Mr. SIMS. Thirty days is the VA standard and we have maintained that level at this point. We have mechanisms in place that make sure that a patient is seen within that 30 days.

Mr. ALLEN. Do you measure that every month?

Mr. SIMS. It's a monthly measurement, yes.

Mr. ALLEN. If I could just turn to Dr. FitzGerald, if you could address the same issue from the point of view of the different hospitals in VISN–1. How is Togus doing compared to others?

Dr. FITZGERALD. I think that when one looks at the surveys that we have relative to timeliness of access, you will see on the national reports that we have, that all of the facilities in VISN–1, while initially above the private sector standard for 1996 and 1997, in 1998 have all dropped below the timeliness in access standard

in the private sector; and are some of the most, by the standard, by the survey, some of the most accessible. From a network perspective, I can look to the reports that we get on the prosthetics clinics that support the prosthetics area, where we find that all of the facilities in VISN–1 are within the acceptable standards for the VA or very close. I think there is one of the five or six clinics there, and I mention this in the report, that is 1 day above the standard, and I think that's 5 days or 6 days with a standard of 5 days.

So I think that from an access point of view, based on that information, Togus is in a comparable field and in a very—more than two standard deviations above the rest of the VA. That is not to say, however, that there are not unacceptable problems with access given the unique features of the Maine geography and the needs of the Maine veteran. And we clearly find it unacceptable for the MRI situation, for the radiation therapy situation, where we have encouraged and funded the management contracts for the provision of local service, not in one area, but in three areas throughout Maine because of the difficulty in getting from a Caribou to a Togus. So we are trying to deal with the accessibility.

On the primary care side, as you are aware in our previous discussions in October 1997, in our meetings, there was an access problem, particularly in primary care; and we have moved to try and solve that problem. Recruitment is an issue, however.

Mr. ALLEN. I thank you all.

Mr. SHAYS. Thank you. Mr. Gilman, you have the floor.

Mr. GILMAN. Thank you, Mr. Chairman. For Dr. Garthwaite, the Coalition of Northeastern Governors recently called on the VA to answer three questions concerning the impact of VERA on the quality of care and services in the northeast. And that was signed by the Governors of Connecticut, Maine, Massachusetts, Rhode Island, New Jersey, and New York. The CONEG statement said, "Millions of dollars and hundreds of employees have been cut from veterans' facilities in the Northeast. Meanwhile, these assets are being transferred to southern States under the guise of placing assets in the locales into which veterans are moving. We feel it's unfair to decrease the care of one veteran in order to increase the care of another veteran." My question is why does VERA fail to recognize the historic higher cost of providing health care in the Northeast compared to other regions in the Nation?

Dr. GARTHWAITE. I think there are a couple of issues embedded in your question. The first, the simplest answer is that it doesn't fail to take account for the higher cost. The price per patient paid in VISN–1, VISN–3, in New York State, for instance, is significantly higher than the price paid per patient in other parts of the country. And that is because there's an adjustment for the case mix, and there are more patients with chronic diseases, AIDS, or mental illness in some VISN's. There's an adjustment for the cost of living. The cost of the salaries we must pay health care professionals in the New York area and in and around the Northeast is higher. There are also some other adjustments for research and education. VISN–1, 3, and 13 have six medical schools each. They have a significant amount more education and research, there's an adjustment for that.

Even when you account for everything that we can think to account for, and we're open to other suggestions that we can study, we find that there is an unexplained variance in the cost of delivering health care in certain parts of the country. And if you look at Dr. Weinberg's work from Dartmouth Medical College, where he has looked at the HCFA, the Medicare data base, they find exactly the same problem. There are unexplained differences and variances in the way health care is delivered around the country that do not appear to be explained by any obvious thing, other then physicians and others deal with diseases differently in those areas.

Mr. GILMAN. What you're saying is essentially is that the costs are higher then in this part of the country, are you not?

Dr. GARTHWAITE. And the model does account for that, but there are still additional dollars being given to the northeast; and according to the model that were not accounted for by those things, which include, as I mentioned, cost of living, the case mix of the patients, the severity of illness of those patients, and so forth.

Mr. GILMAN. But you're confusing me, doctor. You're saying on one hand you have additional costs, and on the other hand, you're taken away funding from this area and shifting it to other areas. What's the rationale for that?

Dr. GARTHWAITE. Let me try, I see why I'm confusing you, and it's my fault. What I'm saying is that there is a way in which clinicians in certain areas of the country order tests, the rate at which they perform certain procedures, the way in which they prescribe certain kinds of medications that cost significantly more in certain areas of the country than others without any demonstrable improvement in the outcome of patients. It is simply that practice patterns are somewhat more expensive in certain areas.

Mr. GILMAN. All right, we agree that they're more expensive in this part of the country. But why then, if they are more expensive, do you shift the responsibility by taking funds away from the area?

Dr. GARTHWAITE. We were asked by Congress to more equitably distribute resources. As we looked closer and closer at that, it became clearer that at least part of the distribution of funds was related to things that were not attributable to the patient mix or the cost of living in those areas. They were the habit strength of the way the systems deliver the care or they had some inefficiencies in the delivery systems. We have tried to correct a lot of those delivery system inefficiencies, and have done so. Redundancies in programs at two Boston hospitals, I think are a good example of where we found that 95 percent of the programs in two hospitals 6 miles apart were the same. Five percent were unique. We went forward with a study to combine those two hospitals, at least the in-patient part, combine those programs, and improve the efficiency. It's those inefficiencies that were more prominent in certain areas of the country that needed to be extracted.

Mr. GILMAN. Well, we certainly agree——

Mr. SHAYS. Would the gentleman yield?

Mr. GILMAN. Yes, I'd be pleased to yield to the chairman.

Mr. SHAYS. Has that happened yet?

Dr. GARTHWAITE. We have agreement and a decision on where that's going, and we've begun the implementation. Dr. FitzGerald——

Mr. SHAYS. No, but for the record, it has not happened?

Dr. GARTHWAITE. It has not fully happened. That's correct.

Mr. SHAYS. So it hasn't happened yet? Not fully. It hasn't happened. It's all talk still?

Dr. GARTHWAITE. I would say it's beyond talk in terms of the kinds of agreements and the steps we need to take to make it happen.

Mr. SHAYS. There are signed documents, so it's a talk in writing. But it hasn't actually happened yet, for the record?

Dr. GARTHWAITE. We have not merged the two hospitals. Is that correct, Denis?

Dr. FITZGERALD. That's correct.

Mr. SHAYS. Well, that's an understatement, correct? It hasn't happened. For the record, have these hospitals been merged?

Dr. FITZGERALD. No, they have not, sir.

Mr. SHAYS. Thank you.

Mr. GILMAN. Thank you, Mr. Chairman. Again, you have great ideas and efficiency and trying to reduce costs is something we all agree with, but you're in a high-cost area. And you're not recognizing that by taking funds away, you're reducing the quality of care. Let me ask you also, why is the VA moving away from providing long-term care to the chronically ill veterans and assigning that responsibility over to the States? That's not fulfilling a proper responsibility to our veterans, is it?

Dr. GARTHWAITE. I'm not so sure we're moving away from providing long-term care to our veterans. We have legislative responsibility to provide nursing home care to veterans who are in the nursing home because of a service-connected condition. My understanding—the law does not provide long-term nursing home care to any other veterans. We have the discretion to do that and have often provided that care to a significant number of veterans whom the law does not mandate, or necessarily fund that care. We are very interested in providing long-term care. I think it's a need for veterans, and we need to be involved in that. And we will within the next several weeks, as soon as the printers are finished, have a report from an outside committee that has looked at long-term care in the VA. We would hope to engage you and many others in a discussion about appropriate future involvement of the VA in long-term care of veterans.

Mr. GILMAN. But at the moment, you're turning them out on the street, are you not? You're not providing that long-term care for chronically ill?

Dr. GARTHWAITE. Sir, we're not able to provide long-term care for everyone who might need it. We certainly provide it for all service-connected veterans who need to be in a nursing home for their service-connected condition and a significant number beyond that. Last year, we paid for more nursing home days of cares than we did the previous year. I can get you the exact numbers if you care.

Mr. GILMAN. But there is a large number of the chronically ill that you're not able to take care of, is that right?

Dr. GARTHWAITE. That is true.

Mr. GILMAN. According to the American Legion, under VERA, fiscal year 1998, there were 16 VISN's that gained dollars and 6 that lost dollars. Of the six VISN's that lost dollars, four in the North-

east corridor from Boston to Washington, the heaviest populated region in our Nation. And according to the VA, 13 VISN's would receive increases in fiscal year 1999, 9 would receive less funding, including VISN–1, which would lose $38 million, a reduction of 4.35 percent. And in your testimony, Doctor, you say, "VERA is based on validated patient workload and includes adjustments for variance in labor cost, research, education, equipment, and facilities maintenance needs." Is that your statement?

[Dr. Garthwaite nods in the affirmative.]

Mr. GILMAN. Would you please describe then the rationale under the VERA formula, which led to the fiscal year 1998 reduction of allocations to VISN's–1, 3, 4, and 5, the most populated area in the country, from Boston to Washington, during a time when the number of patients in that area has been increasing? Could you explain that for us?

Dr. GARTHWAITE. Sure. The distribution of dollars is based on the number of patients who we see and the relative illness burden, case mix. And it's also based on what we think, after adjusting for those factors that you mentioned, and we talked about before, is a reasonable amount of money based on what other parts of the country are able to deliver in terms of care for similar amounts of money. So when you run that formula, there's a significant difference in several networks compared to what would be considered the national average price. We did not attempt to adjust that price in 1 year. We've delayed that and stretched it out. We put caps on that. We maintain reserves to allow that transition to get the alignment of resources and the actual care delivered to be in better alignment. And so what you're seeing is a continued adjustment that's been delayed over time. Once we have that adjustment done, then the future budgets will depend a lot on the amount that the Congress gives us.

Mr. GILMAN. Are you short of funding this year for health care? Is there a deficit in what you need for health care for this year?

Dr. GARTHWAITE. No, not for this year.

Mr. GILMAN. Did you make a request for any additional money this year?

Dr. GARTHWAITE. No, no, we did not.

Mr. GILMAN. Then why is it that you're cutting back the budget in some other areas where you say you don't have the funding for it?

Dr. GARTHWAITE. We're trying to—well, we believe we're trying to align the dollars, put the appropriate amount of dollars to the areas of the country based on the workload that they're producing.

Mr. GILMAN. Doctor, is there a reserve in the VA budget for health care? Do you have a reserve fund?

Dr. GARTHWAITE. We maintain a reserve at the beginning of the year that's released as we go through the year for unexpected contingencies, anything, hurricanes to——

Mr. GILMAN. How much is in your reserve fund at the present time approximately?

Dr. GARTHWAITE. I'd have to get you the exact numbers, but my sense is we probably have around $20 or $25 million.

Mr. GILMAN. Twenty-five million dollars?

Dr. GARTHWAITE. On a base budget of $17 billion.

Mr. GILMAN. Twenty-five million in your reserve fund.

Dr. GARTHWAITE. Right.

Mr. GILMAN. Are you utilizing any of that reserve for these shortfalls in any of the VISN districts?

Dr. GARTHWAITE. Sure. And that's exactly what we maintain that for so that if a network or a facility had a specific reason and justification for requesting dollars because patient care would be compromised, that's what we use it for.

Mr. GILMAN. Why are you cutting back in personnel in some of the hospitals because of an alleged deficit in your budgeting?

Dr. GARTHWAITE. The real reason——

Mr. GILMAN. If you have that reserve?

Dr. GARTHWAITE. The real reason we should be cutting back is because it makes sense to change the way we deliver health care to move from inpatient to outpatient, or to consolidate administrative functions, or to do a variety of other things. Budget changes require a change in the way we deliver health care. If we determine that we've been inefficient in the way we deliver health care, we now want to move to a more efficient way of delivering health care, and that efficiency, in fact, requires a different set of personnel do a different set of jobs, and that's a management action that should be taken to make that efficiency better.

Mr. GILMAN. I regret my time has run out. Thank you, Mr. Chairman.

Mr. SHAYS. Thank you. I'm going to call on Mr. Baldacci, but I want to just quickly ask something just while it's fresh. Doctor Garthwaite in response to the request on whether the VA requested more—let me just preface this by saying Congress has to be held accountable if we don't appropriate the necessary funds. And it would be disingenuous for us to beat up on the administration that has to do this if they request it and didn't get it. Sometimes the Office of Management and Budget is not eager to have line people respond to these questions, but we're under oath and we need to make sure we have the accurate information. Did the VA request more funding than OMB gave them?

Dr. GARTHWAITE. For this year?

Mr. SHAYS. Yes.

Dr. GARTHWAITE. No, sir. As a part of the budget agreement, we had a 5-year agreement.

Mr. SHAYS. So the VA received what it requested from the President. He put in his budget what you all requested?

Dr. GARTHWAITE. It was discussed and really agreed to the prior year. But that's correct essentially.

Mr. SHAYS. OK. As part of the budget agreement?

Dr. GARTHWAITE. Right, as part of the 5-year budget agreement. We had agreed to a 5-year budget plan. We were one of the few people that had done that.

Mr. SHAYS. But did you request more than you were ultimately given?

Dr. GARTHWAITE. The answer from appropriations, no. But as part of the agreement in the budget projections over that 5 years, we had in there some additional things that we will need and made several assumptions. For instance, we had in that original budget agreement that in the out years, we would get Medicare sub-

vention, both first as a pilot, then as a longer term solution to bringing in non-appropriated revenues to the VA.

In addition, at that time, health care inflation was stable at around—semistable at around 2 percent. It's significantly higher than that today. And since that time, there have been a couple of diseases and treatments for diseases, Hepatitis C among those, but also the provision of emergency care which we would need statutory relief on that I think have made the budget agreement less certain and less predictable.

The answer to your question succinctly is at the time of the balanced budget agreement, we had agreed with certain premises and certain understandings to go forward with a flat budget, but to get the third party collections to be kept at the VA and that has happened, Congress has given us that permission and we're doing that.

Mr. SHAYS. It has not happened, you said?

Dr. GARTHWAITE. It has happened, and we are doing that.

Mr. SHAYS. OK. Well, I'm going to come back to you, but if you would just outline to me how much money in the budget you had anticipated getting over these 5 years versus how much you are getting; and how much additional money you feel you need beyond that because if you don't do that, then it's your problem, not ours. And it's your fault, not our fault, candidly.

And, Mr. Ng, I'm going to be asking you some questions about consolidation because we in Connecticut accepted a bitter pill for the recognition that there would be savings that we felt would then be utilized in Connecticut. And we were willing to take, candidly, the political hit on that. And it just irks the heck out of me to think that when we did it, it then went to a group in another State that wasn't willing to take the hit, and they gobbled up that savings. And I think that's just absolutely deplorable.

And another area that I'm going to want to get into is to know, when we have done these savings, Mr. Sims, whether you consulted the people who work for your department, the union members as well and the veterans as to how best to achieve these kinds of savings? Those are the kinds of questions I'm going to want to focus in on.

Mr. BALDACCI. Mr. Chairman.

Mr. SHAYS. Mr. Baldacci.

Mr. BALDACCI. Thank you very much, Mr. Chairman. And I appreciate all the Members' probing questions, but I'm pleased first of all that you're going to be looking at contracting out. And also, just in regards to VERA and its implementation and how you weight it, I just couldn't help but notice in Dr. FitzGerald's testimony on page 2, he said that, "In addition, despite projections and studies that conclude there is a decreasing number of veterans within New England, the overall workload has not declined considerably in the past few years." Our VISN, in fact, has experienced an increase in the number of out-patient visits in the overall number of veterans being served. And if there is some amendment or adjustment that needs to be done to the calculation between what the central office and the regional office are looking at and dealing with, if that, in fact, would be some accommodation, I would request that you would look at that and work with the region in regards to that.

The second thing is that when we went ahead with the VISN–1, it was decentralization from the central administration, and I would ask you have you seen a reduction, or is there a reported reduction in the central administration and in a transference of the responsibilities through these regional VISN's?

Dr. GARTHWAITE. Yes, yes. When I arrived in Washington 3½ years ago, the headquarters, FTEE was 800, it's about 530 now. We've also decreased from regional staff down to network staff, we actually lost some individuals that were FTEE in that move as well. So we have taken some significant changes in headquarters, and are in constant communication with the networks. And I think it really has become a negotiated—and to the extent that it's possible that it's a national system that's politically sensitive, it's about as decentralized as we can make it in 3½ years.

Mr. BALDACCI. A third suggestion is that as you're looking at Medicare subvention, third-party reimbursement and even the ability to handle military retirees. And I notice in some parts of the country they do a better job of that maybe than in other parts of the country. I suggest that you look at those issues in those pilot programs for the Northeast in regards to the concern for what's going on and maybe that will help us to be able to augment the decline in the revenues if we, in fact, end up being the pilot sites for those inclusions of revenues. As you're looking at it, and I'd like to work with the chairman and the members of the committee and others to advance those, if you need any legislative authority to be able to do that, but I think that would be a nice match.

Let me just tell you in Maine what I see happening. What I see happening is I see a veterans hospital that all of a sudden ends up becoming a turnstile to go to Boston. And how it does that is that maybe it isn't in the numbers, but it's the type of care, it ends up going from an acute care facility to a dependent care facility. It doesn't have the staff or the nucleus in order to treat the patients, and because of a consolidation at Boston, they're given the bus ticket to go down to Boston to get this care and at least if you look at an overview of the VISN, it seems to be working OK, but it's to the detriment to the veteran that it's all occurring. And what concerns me about that is once you lose the nucleus, I don't care if its shipbuilding or whatever it happens to be, you're never going to get it back again. And you end up becoming an outpost, a clinic in itself in regards to a community hospital. And I am very concerned about that.

And I don't want to get into the numbers at this time that Mr. Sims has put forward, but I understand that the neurologist that's on board won't be on board at the end of the month. They have another opportunity, another occupation. And probably a third of the referrals that are going to Boston for the MRI's will continue to go to Boston for the MRI's until we shore up that situation. That's a concern to me. That's not my job, that's his job, and that's your job.

And we're spending an inordinate amount of time trying to become somewhat expert at this so that we can try to make sure that our veterans get the treatment that they deserve. I see that happening. And I would try to make sure that the decentralization that you have encouraged at the central office to the VISN's be looked at to the hospitals themselves, within the States, to decen-

tralize the responsibility, authority, and the resources there because I don't see that happening at VISN. What I see happening at VISN–1 is a patient-doctor ratio that's above the average. They have more doctors to patients than the other hospitals within the VISN. I see a transference of patients from the outlaying outposts to Boston that both help them in saving costs in their budgets, but helping Boston to bump up its numbers in terms of the average load and how the national office looks at the patient-doctor loads, the x ray to patient loads, and all of those figures that everybody looks at.

And I guess the most frustrating thing for me is that when I sat down with Jessie Brown and we went over VA Togus and how it was performing its services, and how effective and cost effective, and how dedicated the support people were, and they deserve a big pat on the back because they're doing yeoman's work. In doing the work, he said to me, "Don't worry about VA Togus because they're all within the parameters of what we're looking at nationally." And then somehow when it got to Boston, it got lost in the translation and ended up in Maine, ending up being the crumbs off the dinner table. And it's very frustrating to watch that process go through.

And I appreciate the Members talking about what they did in Connecticut and the consolidation and the hardship and pain that they absorbed, in New York, in Connecticut, and other States, but then seeing what's happening or not happening is really a tremendous concern. So I guess that I wanted to share with you what I see to be some of the issues, and willing to work with you to speed up the implementation of contracting out. We'll look at the updating of VERA, and take into consideration these figures and the discrepancies to see if there's any way to change the weight, to speed up the test sites for Medicare subvention, third-party reimbursement, military retirees under Tricare, and all of those options to try to give VA Togus and other VA's in the region the resources, and decentralizing some of the responsibilities away from VISN–1 to the field.

I just have to say that I appreciate the opportunity to have this with you—this session and appreciate the subcommittee undertaking this.

And I guess I can't let Denis go without a question because we've enjoyed our working relationship over these very few years. And, God, I think that if I didn't know anything about the restaurant business, I think I'd end up having to see if I didn't have any skills that I could work at the VA after I get done with on-the-job training. But I would like to ask you, Denis, Dr. FitzGerald, do you support Togus as a fully staffed community hospital, first?

Dr. FITZGERALD. As you know, Congressman, in our initial strategic plan, Togus was designated as a community hospital within the network. It continues to carry that designation in that plan and in the update, and I believe it will continue to show that designation going forth into the strategic addendum so to speak that will be due 10/31 this year. Those services that are outlined in that initial strategic plan further define a community hospital, and gives the director the authority to investigate and to either make or buy those kinds of services within available resources. Clearly, we understand the uniqueness of Togus and have so recognized that the

accessibility that we see there in certain areas is not acceptable. And so we're moving to correct that as rapidly as we can, again, within available resources.

Mr. BALDACCI. Dr. FitzGerald, in regards to available resources, have you presented a plan in order to be able to attract additional resources in terms of Medicare subvention, through third-party reimbursement, and alternative revenue sources? And have you presented that plan to the national office?

Dr. FITZGERALD. We are working with—we have requested to be part of the Medicare subvention as a VISN. We are working certainly with the Tricare group, and we have recently signed a contract for the Tricare area. And we are continuing to look at throughout the network, and that would apply to Togus as well, through other sharing arrangements to enhance the revenue stream. We have recently, in our MCCF collections, in our collections from outside insurers, we are a leading VISN in that area, and Togus has done yeoman's work in collecting from those outside revenue sources additional moneys which have come into the VISN. So the answer to your question I believe is yes.

Mr. BALDACCI. Let me just end I guess by telling you and suggesting to you that I appreciate your commitment to maintaining Togus as a community hospital within available resources, and a commitment to seek additional resources to make sure that it maintains itself because not one more cancer patient, not one more MRI patient, should have to travel 250 miles and give up at least the course of a day with their families for treatment that should be readily available, from the numerous medical facilities that there are in our State. That should not happen. And there should be a commitment that that should not happen from the VA and the national offices. Because, frankly, you're going to continue to have the Maine delegation, the Connecticut delegation, all the other delegations until that situation is reversed.

Dr. FITZGERALD. I agree.

Mr. BALDACCI. Thank you, Mr. Chairman.

Mr. SHAYS. I thank the gentleman. Mr. Ng, why did you consolidate both the West Haven facility and the Newington facility?

Mr. NG. A major reason for the consolidation or integration of Newington and the West Haven facility is an opportunity to recreate the two hospital system into a health care delivery system which better serves the veterans in the State of Connecticut.

Mr. SHAYS. The fact is, however, we had to eliminate duplicative services in that consolidation practice. There were some services that were not provided at one facility or the other, is that not correct?

Mr. NG. With that recreation, yes, we have avoided duplications so that we can achieve efficiency to reinvest, to develop new programs and access points to the veterans.

Mr. SHAYS. So the purpose though was to maximize a program and each facility, to specialize in each facility and in the process save money, the opportunity cost was that you could then spend it somewhere else?

Mr. NG. That is correct. The reinvestment enhanced programs.

Mr. SHAYS. Was it your impression when you made these arguments to us that some of the savings that you would realize would go to other parts of New England and other parts of the country?

Mr. NG. When we first discussed integration, the VISN concept was in its infancy. So there was not as much focus on sharing resources.

Mr. SHAYS. Isn't it true though that in your arguing to the Connecticut delegation and to the veterans that you claimed you would improve services because you would be able to maximize your resources. So isn't it a fact, truly, that you envisioned and made us feel that we could rightfully expect that while we could take heat for reducing services in some ways, we would see improvements in others?

Mr. NG. That is correct. The reinvestment overall is better for the veterans.

Mr. SHAYS. And isn't it a fact as well that when money was taken from the Connecticut system and other parts to fund the inefficiencies in Boston, that one of the explanations when you had to reduce your own budget was that some resources were being taken from the Connecticut facility. Is that not true as well?

Mr. NG. I can only look at the Connecticut budget from the start of integration since we achieved the efficiency. We have been able to do more with less.

Mr. SHAYS. I love that. We're all doing more than less. But you are here and this isn't a game. I am asking you a question and your superiors recognize you are under oath. Therefore, you just need to be as candid as can be. Isn't it a fact that some resources that were being provided for the Connecticut system were taken away?

Mr. NG. We have less resources from the beginning, that's true.

Mr. SHAYS. And isn't it true that part of the explanation was they were needed in other parts of New England and in other parts of the country?

Mr. NG. From an integrated healthcare delivery standpoint, resources are shared among facilities and that was the concept and that is the concept.

Mr. SHAYS. You know I am going to press you a little bit more. It would be easier for you to be a little more candid because I am just going to take as much time as is necessary. Because it is not fair to anyone, to the veterans or to us as Members of Congress that are going to listen to each one of you. It is not fair to say something in private, to say something in a public meeting, and then when you are before a committee to not say the same thing.

I will tell you this. It was my understanding as a Member of Congress that when we complained about a retraction of services in Connecticut, after we had already gone through the consolidation and taken a hit, that the honest explanation, this is not a criticism, but the honest explanation was that we needed more resources in other parts of New England, in part because we hadn't done the kind of consolidation in the Boston area. Isn't that true?

Mr. NG. That is correct. As discussed before, the plan for Boston has been developed but has not been implemented.

Mr. SHAYS. OK. There's nothing to be embarrassed about. We put it on the record and then we deal with it.

The bottom line, as I look at it—now in terms of, let me just get to one other point with you. I was impressed with how you did the consolidation. I think I know why you were successful, besides having great Members of Congress that cooperated.

Mr. NG. Absolutely. With you, Mr. Chairman, as the leader.

Mr. SHAYS. No. Rosa DeLauro was clearly right there.

Mr. NG. And Rosa, and Mrs. Kennelly.

Mr. SHAYS. And in the Newington area is that Mrs. Kennelly's?

Mr. NG. Yes, Mrs. Kennelly.

Mr. SHAYS. In fact you got both Members from the actual area to sign off on this process and the others agreed. But the bottom line is, why do you think you were successful?

Mr. NG. I think I was successful because I was fortunate to have veterans' groups, employees, medical schools, congressional delegations, and a State that pulled together to help me and help the senior management team to recreate a system that's better for veterans. People see this as a great opportunity.

I feel that we are also successful because of the intensity in our communication with our stakeholders, to let them know why we are doing certain things, why a certain decision was made, and the pre-decisional process was utilized to make sure that there was enough buy-in before we implemented new development and changes.

Mr. SHAYS. I concur that I think your success was that you involved stakeholders, all of them. You involved them and you listened to them. In the process of listening, you made some changes to what you probably thought was the best way to go. Maybe you still thought it was the best way to go, the way you wanted to proceed. I think basically it was your plan. But you realized that this was a process to involve others.

Mr. NG. That is correct. I myself do not have all the answers. All the stakeholders helped to advise me.

Mr. SHAYS. I get the sense, Mr. FitzGerald, that one of the challenges that you are facing in Maine, and Mr. Sims, is that you all have an idea of how to utilize limited resources, but I am getting too many people contacting me directly, not just through Mr. Allen and through Mr. Baldacci, but from veterans' groups as well, that didn't feel involved.

Do you think that you both could be doing a better job of involving the stakeholders in your area in this process?

Dr. FITZGERALD. In the area of integration in Boston, sir? Or you are talking about in the Togus?

Mr. SHAYS. Excuse me, in terms of, you know, let me back up because I am mixing apples and oranges here.

Mr. Sims, you have less resources. Correct?

Mr. SIMS. No. As a matter of fact, for fiscal year 1998, we had more resources than we did for the previous fiscal year.

Mr. SHAYS. How much more?

Mr. SIMS. Approximately $440,000.

Mr. SHAYS. Describe to me why you think there's tension in your area over the services that are being provided.

Mr. SIMS. Because as has been mentioned previously, the health care delivery is undergoing tremendous change in the way it's being provided. The shifts from inpatient to outpatient, the ambu-

latory surgeries, the shorter lengths of stay, the different venues for provision. Those changes are very troubling in many respects to both the veterans and to the providers as we try to make that shift. I think that's frankly the primary reason that there is the unrest.

Mr. SHAYS. Mr. Ng, you had to consolidate, but you also had to deal with network service lines and a whole change in concept as well. Are Connecticut veterans different than Maine veterans? I mean I get the sense that, and I have gotten direct complaints from participants in your facility that they weren't involved in this kind of process. Is it your testimony that you have fully involved them and that they have been part of the decisionmaking process?

Mr. SIMS. We have involved right along. You had mentioned earlier the union. We were one of the first facilities, VA facilities in the country to implement a formal partnership agreement. Certainly we have worked very cooperatively right along with the union. We have included employees. We have focus groups, as we have discussed changes. We recently were discussing the possibility of changing a designation of our surgical ward into a day procedure unit. As we got into that involvement with both the union and with the staff in that area, it became apparent that that was not the right way to go. So we have changed direction there.

As we have changed our PTSD program from an inpatient program to an outpatient program, we held numerous meetings with groups of veterans around the State to share with them what our thoughts were, to get their input into that. We continually involve our stakeholders with the things that we have going on. We have a management assistance council, as does every other facility and then at the network level also, the management assistance council, wherein we share information, request input on strategic direction that we're going.

So while there is probably always room for more inclusion, I feel at this point we have done a good job of including those people that are involved.

Mr. ALLEN. Would the gentleman yield?

Mr. SHAYS. I'll yield.

Mr. ALLEN. Just briefly. Mr. Sims, I mean I have a reaction, which is, I don't think it is fair to describe the labor-management partnership. My understanding, I mean you did go into it and there was work together, but I understand the union has pulled out of that. Is that correct?

Mr. SIMS. There has been an indication, although I have not had any formal notification of that. There is concern at this point about the way that partnership was going. However, I still include and they still attend sessions that we're having concerning strategic planning, budgeting issues, staffing methodologies and so forth. So they are still part of what we do.

Mr. ALLEN. Am I wrong that the union has not pulled out of that partnership or is it your understanding that they have pulled out of the partnership but just haven't sent you a letter?

Mr. SIMS. There has been discussion about concerns and we have tried to establish dialog to improve, if that's what is required.

Mr. ALLEN. Mr. Sims, I have got a letter here to the center director from Helen Hanlan, which says that since there is—the date of

the letter is September 1, 1998, subject, suspension of Togus Partnership Council. I'll read it. It's two sentences. "Partnership appears to have two interpretations. AFGE believes it includes meaningful pre-decisional involvement. Management believes it is intermittent post-decisional notification. Since there is such a difference in interpretation, AFGE Local 2610 has voted to suspend participation. When and if management is willing to address this, please notify AFGE." Signed, Helen Hanlan, president.

Did you receive that letter?

Mr. SIMS. That's the formal Partnership Council. It was a group that met on a biweekly basis. The partnership itself, as I say, the working together with the union leadership still exists.

Mr. ALLEN. I think I'll leave it right there. I yield back.

Mr. SHAYS. Dr. FitzGerald, what steps from your point of view were taken to implement the network service lines?

Dr. FITZGERALD. To implement the network service lines, sir, we discussed that with—we developed the concept of the model of service lines that we felt would be most appropriate, leaving the most flexibility, yet giving the most accountability for the services that were involved. We discussed that with our executive leadership group. We discussed that with the Management Assistant Council. We are in the process of continuing to discuss that with the Academic Advisory Council. We have a memorandum of understanding with both of the major unions and the network, AFGE and NAGE a relative to service line.

Mr. SHAYS. Let me just pursue the union. Be more specific as to how you consulted with the employees in your hospital who are union members. How have you consulted with them?

Dr. FITZGERALD. How have I consulted with the union members?

Mr. SHAYS. As it relates to the network service line.

Dr. FITZGERALD. We entered into negotiations with at the network level with the AFGE leadership and with the NAGE leadership, and came to a memorandum of understanding that the service lines in the model that we are working with will be negotiated through the partnerships at the local level.

Mr. SHAYS. I am obviously referring to the union leadership because you have certain restrictions talking directly to union members. But is it your testimony before this committee that they have been fully consulted and that their views have been implemented to the best of your ability to implement them?

Dr. FITZGERALD. We have a memorandum of understanding signed by the AFGE representatives throughout the network. We have another memorandum of understanding signed by the presidents of the unions across the network of NAGE concerning specifically the issue of the implementation of service lines.

Mr. SHAYS. Dr. Garthwaite, I will obviously need to pursue that because that is not what I am hearing. I don't know if you would be saying what you know to be true, but it's in conflict with what I am hearing from frankly, what at least I thought I was hearing from union leadership. It doesn't mean you do what they want, it means you consult with them, and it means that you value their input and you try to the best of your ability to implement it.

Dr. Garthwaite, you can't undo what has happened, but when I look at it basically we have lost $52 million in the last 18 months

from network one. That is my reading. My reading of the potential is that we could have had a savings during these 18 months of 75. We would have had a cost to integrate of about 30, which left 45. So we could have minimized that loss at 52 by 45 and had a net of 7.

So that is why I jumped on you, frankly, when you talk about the fact that you have an agreement and it's in the process because I want to know when we're going to start to see the savings show up in dollar terms. I want to know how it is going to benefit and how quickly we can see these numbers turn around.

Dr. GARTHWAITE. I will, with your permission, ask Denis to give you the timeframe that he's working under to the integration. It is a disappointment that it's so hard to make fairly radical change. It does require extreme communication and it does require careful listening, and it does require involvement of stakeholders. Sometimes even the mention of the thought of making a change ends up in the papers with hearings and a variety of other things.

Mr. SHAYS. I know people don't make your job easy, but instead of moving Mr. Ng out to Nebraska, maybe you should have moved him up to Boston.

Dr. GARTHWAITE. We need to find where the actual inefficiencies of care are in the networks that at least by all accounts appear to be inefficient. We need to direct our efforts at extracting that inefficiency out of the system, then to make sure that we then spend those dollars appropriately and well. I think that we are attempting to do that.

Mr. SHAYS. Dr. FitzGerald, isn't there the understanding that we will—what is the annual savings after we have—there's by consolidation in the Boston area, it is going to cost approximately $30 million. Am I right on that?

Dr. FITZGERALD. It's a projection, sir.

Mr. SHAYS. But the projection, a projection admittedly, is that we will save 50 by the consolidation. That is what—and so I am looking at a $20 million savings first, and then I am looking at $50 after that. Is that something that seems realistic?

Dr. FITZGERALD. The projection for expenditures to prepare the system for the integration are $30 million in capital expenditures.

Mr. SHAYS. And what are the savings?

Dr. FITZGERALD. The projections on the savings over 5 years, the present value was $100 million.

Mr. SHAYS. Netting out the $30?

Dr. FITZGERALD. I'm sorry?

Mr. SHAYS. Netting out the $30?

Dr. FITZGERALD. It's possible but I would have to go over how you——

Mr. SHAYS. Let me say it this way. It is a net savings of $100 million over 5 years?

Dr. FITZGERALD. That is what we're intending. Yes, sir.

Mr. SHAYS. So I make an assumption that it's 130 minus the 30 give or take the present value.

Dr. FITZGERALD. Yes, sir.

Mr. SHAYS. Well, I want to pin you down as to when this is going to happen.

Dr. FITZGERALD. Well, we have been working with our stakeholders since December 1996. That culminated in a report in May 1997 with a recommendation. There was unanimous agreement to do it. There was unanimous agreement to put it in one place. There was unanimous agreement that there was no bad decision as to which place. But there was significant disagreement as to which site to put it at.

It was felt at that time in May 1997 that we would enter into a national steering committee, which was formed and another consultant was brought in to look at the integration. That took approximately a year.

Mr. SHAYS. With all due respect, it sounds more like a political problem because you are saying either site would be good.

Dr. FITZGERALD. Yes.

Mr. SHAYS. So just close your eyes and pick one, and then save a lot of money in the process.

Dr. FITZGERALD. Yes, sir. That decision was made in June, approximately June 1998, and we're now moving forward to select leadership for that integration.

Mr. SHAYS. You have to move more quickly than this.

Dr. Garthwaite, you can't continue this. One of the solutions is to simply say this is your money and if you want to have two facilities and have that kind of money, be our guest. But it is just wrong to take from other places when we have done our job. I just think it's wrong. Maybe I sound a little inconsistent because I am saying you have got to get the stakeholders to agree, and now I am saying in a sense, the stakeholders don't want to act. But I don't think I am because what I think you can do is say this is the money you have got available, now what do we as stakeholders do.

I am willing to get to the next panel unless others have it, but I still haven't gotten an answer as to when we are going to get this done. I am concerned because this could just drag on and on and on.

Dr. Garthwaite.

Dr. GARTHWAITE. I can easily commit to you that we will intensify our efforts, but we believe we have to do it and do it quickly. The financial incentives are there. The argument you just made is exactly the argument other networks make about dollars in the northeast. So that they say we have given, we are more efficient, they need to get more efficient. But I totally hear what you are saying. We'll push as hard as we can.

Mr. SHAYS. Doctor, with all due respect, of the six that have less money, four of them are in the northeast. There are 22 networks. Six have lost money and the rest have gained. So I mean that's——

Dr. GARTHWAITE. But the money has been delayed in its shift and so forth, so they make that argument.

Mr. SHAYS. I think a weak argument.

Dr. GARTHWAITE. Maybe.

Mr. TOWNS. Mr. Chairman. I really don't have a question but I really want to put something on the record that is really bothering me. That is the bonus concept. You know, I am having difficulty with that. I think that people should be paid, and I am one that believes in paying people, and the fact that you lost four pharmacists, I mean that troubles me because this seems to be a prob-

lem, you know, when things like that happen. But then at the same time, I look at the bonus concept as I understand it, that if you are able to save money in a certain area, then at the end of the day, therefore based on the fact that you were able to save, now you get a bonus.

I think that when we look at the bonus situation when it comes to healthcare, you can't look at it as you would do in other industries, whether you are able to increase in terms of your sales in a certain area, therefore based on that you give a bonus. I think that if you are going to give bonuses in healthcare, it should be based on the fact that people live longer, and as a result of their living longer, therefore you are now given some money because of the fact that you have increased their life.

But the point is that when I look at it in healthcare how you can play the numbers game, and it bothers me. Because a person can come in with something that's very serious and then you sort of ignore it because the point is that you are looking at the bottom line, looking at the budget. At the end of the day, that particular year, you get a bonus. But at the time same, the next year all these people die. I mean because the point is that we did not pay the kind of attention that we should have paid.

Mr. SHAYS. Would the gentleman yield?

Mr. TOWNS. I'll be delighted to yield because I'm troubled by that.

Mr. SHAYS. We're going to have a friendly disagreement, just for the record. The friendly disagreement is that I think it depends how the bonus is paid. But if you have two facilities that are operating below capacity and you make those kind of consolidations and save money, I think that is good management. I think good management needs to be rewarded.

Mr. TOWNS. It goes beyond that, Mr. Chairman.

Mr. SHAYS. But if it's eliminating a vital service and then claiming a savings, then I concur. So I think I just want to qualify it and say that in my judgment, thank you for letting me make this point.

Mr. TOWNS. I don't have a problem with that. Actually we are agreeing. I think the part that I am having problems with is that if a person comes in and that based on the type of diagnosis, you look at a situation and you say well, we're not going to bother to treat that because the point is that we'll just sort of let the person move on based on whatever.

I mean the point is that I am saying, Mr. Chairman, is that bonuses have to be in healthcare. You have to be careful with those. I mean that is all I'm saying. I don't think we disagree. I think that if you consolidate and you save money and you give a bonus, that's one thing. But I am saying it goes beyond that. I mean even in regions in the country. I mean there's a lot of problems here with this.

So I think we have to be careful with the bonus and look in terms of paying people the way that we should pay them rather than getting into that kind of game. That is all I'm saying. I think that's from a budgetary standpoint. I think that we have an obligation and a responsibility on this side of the aisle, even if they don't ask for the money, if we feel that they need it, then I think we

should give it to them. I also understand that when you come in as a staff person, that sometimes it is very difficult to sit over there and say certain things because that can eliminate your bonus too. I think that we have to also recognize that. That is what I'm saying, Mr. Chairman. I am troubled by it.

I have all due respect, I mean I think that for you, and I think that at some point in time we need to take a look and say hey, they need more money based on the fact that we have been able to talk to them, we have been able to see this, and we need to make certain that if we are concerned about veterans, we need to give them the dollars to make certain that they provide the service. That's all I am saying.

Mr. SHAYS. And you have the last word on this. I invite any of the panelists to make a closing comment if they would like to.

Dr. GARTHWAITE. I would just like to respond to the issue of bonuses. We do not give bonuses because people save money. We give bonuses very clearly based on performance. The performance has a variety of pieces. The most important thing are improvements in patient satisfaction, access to care and quality of care. We have quarterly reports and yearly reports that detail exactly what it is that's all about the care to veterans. It's a new different system.

Mr. SHAYS. Since you are on the record, you said you don't give it based on savings. It is a part of a much broader basis for giving bonuses.

Dr. GARTHWAITE. The networks get an allotment based on VERA. They can't save that money.

Mr. SHAYS. You're on record. It would be I think pretty difficult to accept that if you have an efficient manager who is saving money, that that is not a factor.

Dr. GARTHWAITE. There are measures of efficiency in the overall performance contracts that we sign with our network directors. There are. But they are not the only piece. They are a small portion. I think that is a fair thing to do.

Mr. TOWNS. Let me just make sure I understand. If you have a vacancy in terms of you are looking for a neurologist and you can't fill the spot, you give a bonus to recruit somebody to get them to come and take that job. Is that true?

Dr. GARTHWAITE. We have a minimal ability to give a recruitment bonus. We have some significant salary limitations for recruitment in the VA. So we can give I think up to $25,000 as a rarely used personnel possibility. It requires a lot of paperwork and it's just a piece that we have used on occasion, but it is rare.

In many cases, our salaries are comparable and reasonable. In some areas they are not. Some areas we lost contracts to get the appropriate care. It's a long discussion.

Mr. SHAYS. Any other comment before we go on? Dr. FitzGerald.

Dr. FITZGERALD. No, sir.

Mr. SHAYS. Mr. Sims. Mr. Ng. OK, thank you, gentlemen.

Our second and last panel is Bruce Woollett, Department of Dentistry, Togus, ME; Jack Bachman, Department of Neurology, Togus, ME; Neal Williams, disabled Vietnam veteran, member, Military Order of the Purple Heart, Greenville, ME; Robert Hite, national field representative, American Legion; and Linda Schwartz, president, Project Partnership, Pawcatuck, CT.

I invite them all to sit down. In this case, I don't mind you all sitting and just raise your right hands.

[Witnesses sworn.]

Mr. SHAYS. For the record, all have responded in the positive.

It's really wonderful to have you all here. I want to suggest that I am going to be leaving at 1:30. Mr. Allen will be here until 2 if necessary. We would like you to comment on what you have heard. You have prepared statements. I am happy to have you read them, but they will be part of the record. But I really want to kind of get to the core of the things you have heard. So it is your option, but if you can also respond to questions asked and comments made, I think that would be very helpful.

I think we have you in the order to which we called you. You can just go right down. I'm sorry. Mr. Williams, you will be third. It will go to Dr. Woollett, then Mr. Bachman. Then to Mr. Williams, then to Mr. Hite, and Dr. Schwartz. Thank you. OK. Great to have you here.

Dr. Woollett.

STATEMENTS OF BRUCE WOOLLETT, DDS, DEPARTMENT OF DENTISTRY, TOGUS VAMC; JACK BACHMAN, DEPARTMENT OF NEUROLOGY, TOGUS, VAMC; NEAL WILLIAMS, DISABLED VIETNAM VETERAN, MEMBER, MILITARY ORDER OF THE PURPLE HEART; ROBERT HITE, NATIONAL FIELD REPRESENTATIVE, AMERICAN LEGION; AND LINDA SCHWARTZ, PRESIDENT, PROJECT PARTNERSHIP, PAWCATUCK, CT

Dr. WOOLLETT. Thank you, Mr. Chairman and Members. My name is Bruce Woollett. I work at the VA hospital. I have been there full-time as the endodontist in the dental department for 18 years. Prior to that, I was the consultant in endodontics for 9 years.

What I would like to do is demonstrate how successful our reorganization has been at the Togus VA Hospital. I would like to talk about the bottom line. I still have patients rather than customers. I would like to just bring to your attention one of the many, many patients that I have had to deal with. I selected this one in particular, but I would like to just first point out that Togus, ME, is the only one of the nine VA hospitals that has——

Mr. SHAYS. In the New England area?

Dr. WOOLLETT. No. In the VISN area that have no homeless veteran treatment or assistance program. I don't know why in particular, but I would also say that in the strategic plan of 1998 to 2003, the network's strategy, a goal of the homeless veterans' initiative is that all homeless veterans within VA New England have ready opportunity to establish the highest level of functioning and capacity possible. I would like to bring this as an example to show you how well we are complying with that.

On December 8 last year, I had a patient that was placed in my primary operatory chair. I came in, and I saw on my desk the patient's chart and a consult for a 10–10. A 10–10 means the patient is only eligible to be evaluated for the possibility that his dental problem is so severe that he needs to be hospitalized.

The patient in my chair was a homeless veteran who was also blind. It was obvious that he was very happy to have someone fi-

nally see him, because he had been suffering for a long time. On initial evaluation, just talking to him he was very excited. He had adrenalin in him, probably for the first time in several nights because he hadn't been able to sleep.

On the first evaluation, I saw that his lower jaw was swollen. His lip was quite enlarged. He had several tender areas underneath his chin. I put him farther back in the chair to evaluate what I assumed was at least one abscess, but possibly more. He, this 50-year-old veteran, had four lower abscess teeth. He was wearing an upper denture that didn't even belong to him. That denture, I have pictures of it here, had several teeth out of it. The reason he was referred up to me is because he had an area of erosion on his palate, a result of wearing someone else's denture.

Also, they asked if I would consider doing a biopsy because he had a white area in his mouth. On closer examination, the white area was not solid. It was pus. As I pushed underneath his chin, that pus came up between the tooth and the gum and rolled down into the floor of his mouth. So he didn't need a biopsy. What he did need is to have those four badly abscessed teeth taken out.

Now again, we don't have a homeless veterans' program or assistance program. The previous patient I had seen was a nonservice connected veteran and his consult came through that said he had no dental eligibility. So I had to inform the patient that he was not eligible for care at our hospital.

Mr. SHAYS. I'm sorry. Just explain to me why he wasn't eligible?

Dr. WOOLLETT. I beg your pardon?

Mr. SHAYS. Explain to me why he was not eligible?

Dr. WOOLLETT. He wasn't eligible because he was not 100 percent service connected veteran. Our staffing has been such that we have had to prioritize our patients into who was eligible and who was not. One hundred percent service connected veterans became eligible as well as prisoners of war for more than 90 days. So, all other veterans had to take a lower priority, many of them not seen.

So this patient, because he didn't have any eligibility and was there on a 10–10, I then went to find the chief of the dental department to see if there wasn't something we could do for this veteran. Unfortunately, the chief of the dental department was not there at the time. The receptionist was unable to identify where he might be. I checked the conference room. I started walking back trying to figure out how I was going to tell another veteran that I couldn't treat him.

When I was walking part way back in the hall, my dental assistant, who had walked out of the operatory stopped me and said, "I gave that vet $10." The reason she gave him the $10 was because he was destitute. Now this is a woman with two children, one of which is in college, and she lives in a rent. She is a single mother. She didn't have enough money to be giving anybody anything. She said to me, "If you have any decency, you'll give him $20 or more or whatever is in your pocket."

Well that didn't make my decision any easier. So I went back into the operatory and I again sat down next to him, looked at his chart. I decided that I could not tell this vet that I couldn't treat him. I couldn't do it. But to get some guidance, knowing he was not eligible, if I treated him I would probably find that I would have

a problem. So I called my area representative, John Baldacci's office. I spoke to John Ripley. Basically John Ripley told me to do what I thought was right.

So I treated the vet. I removed those four abscess teeth. I also told him I would see what I could do about getting him some teeth made. Unfortunately we have a waiting list, a long waiting list for even our 100 percent service connected vets. That list is more than a year. Now I was hoping that maybe some way I could help him. That vet doesn't have any dentures today. I mean I got something out of it, but that's another story. But that vet still doesn't have any teeth.

Because of that waiting list, we cannot see class III, VI's and V's. That is kind of a complicated thing, but these are patients that we used to do. I'll give you an example. A class VI, for instance, is a patient who has a medical condition that is being aggravated by his dental condition. Last Friday I had a patient come in who was on dialysis 3 days a week. He was also on insulin. He was a diabetic. He had two reasons to be on two separate diets. They sent him, his dialysis doctor sent him up on a 2-day consult because this patient's mouth looked like a hand grenade had gone off. He couldn't eat anything. Yet I could not treat him.

Now what I want to know is how does that comply with the right care at the right time at the right place? Thank you.

[The prepared statement of Dr. Woollett follows:]

Chairman Shays, Ranking Republican member Gilman; Ranking Minority Leader member Towns, members of the House Committee on Government Reform and Oversight.

I'm Bruce Woollett, a veteran and full time dentist at the Togus, Maine VA Hospital for 18 years and consultant for nine years prior.

I've seen many changes during my 27 years of employment with the veterans Administration.

The Veterans Administration Regional Director in southern New England continues to be unresponsive to pleas from the staff, patients, veterans groups and the state's Congressional leaders. "I've reviewed those statistics," Senator Collins said. "They reveal a dramatic decline in the number of physicians, nurses and physicians assistants, and not surprising related loss of medical and clinical services" "The VA facilities in Brockton, Bedford, and Boston have twice as many full time equivalent doctors for every 1,000 patients as does Togus". Footnote 1

The question becomes why?

I believe there are three reasons.

1. The balanced Budget Act.

2. The priority now given to veterans.

3. To a lesser degree; VERA (Veterans Equitable Resource Allocation).

The balanced Budget Act equates to less money. Veterans are given a low priority. Dan Lynch; "V.A. now stands for Vigorous Attrition". "VA hospitals in the Northeast and the Midwest are suffering gut wrenching cuts. A promise of convenient quality medical care was made by politicians now deceased. To many politicians 'Vietnam is only a nasty memory, Korea and World war II are ancient history. So, the hell with somebody else's promises." Footnote 2

Recently, 10.5 billion dollars was taken from VA (VA will no longer provide care for smoking related illnesses) and shifted to the Transportation Budget. veterans obviously don~t have priority over bridges and roads. I wander if this would have been the case in 1945?

The VERA allocation model does impact the distribution of available funds. unfortunately the basis of this model is flawed. The model assumes many veterans are moving to the sun belt. True, however those are the more affluent veterans. Leaving behind the veterans that need VA care the most! Maine has 154,000 veterans and we see approximately 17,000 of those veterans. The great majority of those vets are poor. I maintain if 100,000 veterans moved out of Maine we'd still see 17,000 plus vets each year. I might add in 1995 at Togus we saw 15,600 sickly veterans. As would be expected, the number of older, poorer and disabled veterans is growing; not shrinking! In any event the combination of the Budget Act, veterans priority and VERA means less money for veterans needs.

The New England health care system pledge to veterans states:

Our Purpose: To serve those who served us so well!

Our Commitment: To advocate for the total well-being of veterans!

Our Promise: To be there when veterans need us!

Footnote 3

"To meet our mission we value: A. Accountability, Compassion, Ethical behavior~ Integrity and Teamwork!"

Footnote 4

Let's see how well the VA at Togus is doing with less money since October 1995, when, under Secretary for Health, Dr. Kenneth Kizer restructured the Veterans Health Administration claiming. ...patient's will get the right care, at the right time, in the right place, at the right cost.

Footnote 5

In 1997 a VISN (New England VA Region) indicator was printed to read the percent decrease of medical doctors per 1,000 patients on a VISN average was 10.5%. However, Togus, Maine had a percentage decrease more than twice the VISN average of 25%. Footnote 6

At a Sept. 24, 1997 press release from the Maine Congressional Delegation, Senators Snowe & Collins and Congressmen Allen and Baldacci in a joint statement "Numerous veterans have expressed their concerns about the availability and timeliness of services provided at Togus, as staffing levels decline in the face of growing veterans population..... We are pleased that the VA has reiterated its commitment to Togus, but it will take actions and not words to rebuild the confidence of the veterans community." Footnote 7

Representative John Baldacci, in a letter dated Nov. 18, 1997 "Dr. Fitzgerald made a personal commitment to insure the viability of Togus well into the future. - . Togus will not close; a core of essential services will remain at Togus; immediate measures would be implemented to eliminate the backlog; critical vacancies would be expeditiously filled and outpatient clinics will be bolstered." Footnote 8

You don't suppose this means Togus had any critical vacancies or any backlog of patients?

Maine Veteran Advocate Gary Burns states Fitzgerald's response to national pressures has come at the expense of Togus. . southern New England is receiving a disproportionate share off the budgetary pie." Footnote 9

Something to think about! Maine is larger than the rest of New England combined. Maine compared to New England has the highest number of veterans and the highest number of 100% service connected veterans per capita. Maine veterans have to travel longer distances to get to a VA hospital; often in some of the most inclement weather in the country. A veteran living 250 miles north of Togus does not want to go to Boston for a 30 minute neurology appointment especially if the veteran is & bi-lateral amputee with diabetes, arthritis,

emphysema, and coronary heart disease

Is the readers credibility sensors beginning to tingle? What was it we said earlier? something about the right time, the right care and the right place. Don't you feel sorry for Boston with its four VA hospitals?

Let me add a few news headlines.

"The plan to improve the Togus Veterans Administration hospital is important because the facility has fallen behind in service that Veterans deserve.... ' Footnote 10

Veterans gather at Togus to protest cuts and spending. "why should we have to ask our country to give us what we deserve'". Footnote 11

"Veterans... Entitlements/Health Care services at Togus VA Hospital are on a steady decline." Footnote 12

Concerns about the future of veterans benefits at Togus VA Hospital. " I (Representative John Baldacci) am particularly concerned about the low morale of the staff caused by difficult working conditions. This not only affects the productivity of the facility but the quality of care given to the veterans." Footnote 13

We're not getting the help promised! "Veterans have to wait a year or more to get dentures." Footnote 14

Reader: How's your credibility antenna doing now?

Congressman Tom Allen states "...I share your concernsregarding the care at Togus. We need to ensure that Togus not only remains a full service hospital, but that it is properly funded, equipped and staffed inorder to provide the quality of care Maine veterans deserve, I hope to see improvements in the service at Togus soon." Footnote 15

Dr. Brown (Chief at staff, Togus VA) "The fact Togus administrators have not done a

good job of explaining the changes to veterans has created a climate of veterans not trusting the administration." When asked of Dr. Brown if we were meeting standards he said "in some instances we are". Footnotes 16 and 17

Dr. Kizer's Text: Prescription for change

"From the time a patient comes through the door until he/she

leaves we must be responsive to the full spectrum of his/her needs". Footnote 18

Then Dr. Kizer said "Situations may arise when due to resource constraints, VA must delay the provision of non-emergent care (delays in clinic appointments or provide tare in a limited number of locations that may not be convenient to the enrolled veteran)." Footnote 19

Which of the aforementioned of Dr. Kizer's statements are true? How does the last one correlate with "the right care, the right time, the right place and the right cost?"

Togus staffers seek Federal investigation

"Maine's congressional Delegation has asked the VA's Inspector General to investigate the Togus VA Hospital following complaints that quality of care there is suffering during re organization." Footnote 20

I have many more quotes including congressional's and answers to consults, etc. but. I think the argument has been made. You can fool someone for awhile but in time your credi bility antennae start to say this is not the truth!

I'd like you to remember what the Network Director wrote "First and Foremost is that any change (in the VA) must maintain or enhance the quality of medical care and services." Footnote 21

WHAT HAS HAPPENED?

When Dr. Kizer submitted his Prescription for Change to Congress he was queried by congress "Dr. Kizer, many attempts have been wade to restructure the VA with only partial success. What makes you think your plan will work? Dr. Kizer's pompous answer "because my plan is the right one!"

Join me in a right against that which is plainly wrong and put justice and honesty back into the VA Administration!

Footnote 1 Kennebec Journal staff writer Dave Cheever

Footnote 2 Albany Times Union Dan Lynch 9/23197

Footnote 3 VA NEBS strategic Plan FY 1998-2003 Dr. Fitzgerald

Footnote 4 Mission statement VA NEBS strategic Plan Dr. Fitzgerald

Footnote 5 1998 Performance Measures strategic Plan Dr. Kizer

Footnote 6 VISN indicators June 1996 Dr. Fitzgerald

Footnote 7 Maine congressional Delegation News Release 9/24/97

Footnote 8 Personal Letter Nov. 18, 1997

Footnote 9 Kennebec Journal sept 2, 1997 "Togus"

Footnote 10 Kennebec Journa l Oct. 22, 1997 The 120 flay Plan

Footnote 11 Bangor Daily News Laura Loweryson, Waldoboro veteran

Footnote 12

Footnote 13 News itelease; Rep. John Baldacci Nov. 19, 1997

Footnote 14 Sun Journal

Footnote 15 Kennebec Journal 1-20-98

Footnote 16 April 26, 1998

Footnote 17 Flagging Support

Footnote 18 'Prescription for change' - Dr. Kizer

Footnote 19 VHA Directive 96-023 April 17, 1996

Footnote 20 stars and Stripes August 17, 1998

Footnote 21 From Network Director Denis Fitzgerald, MD, MHA

Mr. SHAYS. Thank you, Dr. Woollett.

Mr. Bachman

Mr. BACHMAN. Chairman Shays, Congressman Towns, and the members of the House committee, thank you very much for allowing me to be here. A heartfelt thanks to Congressman Allen from myself and the many veterans in the State of Maine who appreciate the effort you have put forth for us, sir.

My name is John Christopher Bachman. I am the chairman of the Committee of Veterans to Save Togus. I am also an Air Force retired captain and a veteran of two tours in Vietnam. I am also a physician assistant who is employed at the Togus VA for the last 10 years. I have a baccalaureate in business management and a baccalaureate as a physician associate and 18 years in the medical field.

Being the physician assistant in the Department of Neurology since July 25, 1997, when Dr. Ian Sanderson left that department, it has survived with the mid-level healthcare practitioner to follow-up on in-patient work and to maintain the spinal cord injury clinic, and to advise the medical staff on neurology in patients who require neurological workups. Prior to Dr. Sanderson's retirement, he gave the administration 60 days notice to allow them to fill this position. When asked at the medical staff meeting which the center director attended what was being done to replace the chief of neurology, it was stated they were looking at the situation and that more data was required before a neurologist, if one could be hired for Togus.

Since that time, we have had four temporary neurologists. Some of them lasting as little as 2 weeks, some lasting 2 or 3 months. The latest temporary, we have just received another one less than 10 days ago who will be leaving on the 30th of September. As the chief of medicine, I have tried several times to secure local contractors for neurology, but to no avail. We have interviewed several physicians for this position without hiring anyone. The temporary physicians have at times actually increased the stress of the staff and especially the physician assistant, which is myself in this area.

The patients have been totally confused and frustrated having seen a temporary physician, told to return in 1 or 2 months either for a followup appointment or special test, to find that that physician is not available at that time. This has created a situation where vets have been angry, and have asked to be seen by a local neurologist. Those vets who are service-connected for 50 percent or more usually can be seen and the VA will pay for it. The vast majority of our patients are nonservice-connected veterans and have two choices. They see the local neurologist at their own expense, or they travel to the Boston VA, which may require some vets to have a 2-day trip for a 20 to 30 minute appointment.

When the patient returns, he is scheduled with myself or his primary care doctor, or he returns to Boston once again for a followup. In February 1998, the chief of medicine and myself arranged with Dr. Thomas Browne, the chief of neurology at the Jamaica Plains VA to see patient consults and to do nerve conduction studies. Dr. Brown also agreed to be contacted by myself if a mission was required or if I was in desperate need to speak to a neurologist in case of an emergency. Several local individuals were contacted, in-

cluding a neurological group in Portland, but this has not produced any better coverage for the neurology system.

At this point, it is my opinion that the situation has zeroed out for quality of care and the continuity of care to the veterans in the State of Maine in the neurology service. Since February 1998, 376 veterans have been asked to travel to Boston for neurological consult or EMG's. We have had several in-patient transfers to Dr. Brown's services this time. At this point, I continue to remain in the Department of Neurology to serve the veterans to the best of my ability with the support of the entire medical staff who cover me, even though their specialty is not neurology.

We have provided the best care possible under this adverse situation. We are hopeful that a neurologist can soon be put on staff.

In summary, I give you this, the medical staff and the surgical staff at Togus that seeks to restore the staffing and services to the level which assure excellent and comprehensive care to our veterans. We seek to renew an environment at Togus that listens to and values our opinion in the strategic planning of clinical service. Without this improvement, we cannot provide care to our veterans which they deserve and expect. Nor can we uphold the mission of our institution which it so proudly proclaims. This summary was signed by 43 of the staff physicians and physician assistants at Togus. Thank you, sir.

[The prepared statement of Mr. Bachman follows:]

CHAIRMAN SHAYS, RANKING REPUBLICAN MEMBER GILMAN; RANKING MINORITY LEADER TOWNS, MEMBERS OF THE HOUSE COMMITTEE ON GOVERNMENT REFORM AND OVERSITE.

HEARTFELT THANKS TO CONGRESSMAN TOM ALLEN, FROM MYSELF AND THE MANY VETERANS IN THE STATE OF MAINE, WHO APPRECIATE THE EFFORT YOU HAVE PUT FORTH FOR US.

I am John C. Bachman, Chairman of the Committee of Veterans to Save Togus. This committee was founded to provide active communication to the veterans of Maine, the Congressional Delegation, State Officials, and the news media to ensure that VAMC Togus remains a fully staffed community hospital, providing all services in health care to our veterans. I am a retiree from the USAF, and a veteran of two tours in Viet Nam in the United States Marine Corps. I am a Physician Assistant, an employee of VAMC Togus for the past 10 years. I have a Baccalaureate from Unity College in Unity, Maine in Business Management and a Baccalaureate from the University of Oklahoma as a Physician Associate. I have 18 years experience as a Medical Professional.

I am here on behalf of the Veterans' Committee to Save VAMC Togus, Maine. I wish to speak about proposed changes to the veterans' health care system that could have an adverse effect on healthcare for the brave men and women who have given a significant part of their lives in service to this great nation.

To understand fully what has brought numerous veterans to question the effectiveness of VA hospitals to provide quality healthcare, we must question the current effects that the "prescription for change" and the veterans equitable resource allocations (VERA) have on the system that provides care to our nation's veterans.

First, what is the mission of the Department of Veteran Affairs? The Department of Veteran Affairs mission statement says that it is "to serve America's veterans and their families with dignity and compassion and to be their principal advocate in the ensuring that they receive the care, support and recognition earned in service to this nation."

Secondly, what are the goals of the DVA? They are numerous and are attached, but one is leadership. That goal is "to serve as the leader within the federal government on all matters directly affecting veterans and their families and to be their advocate in representing their just needs."

Questions that should be asked to the leadership of the DVA by Congress.

1. Does the present leadership truly stand as an advocate for the majority of veterans in this country?

2. Did they foresee all of the effects of the "Prescription of Change?"

3. Did they ask for input from all of the National Veterans Organizations. This should include the DAV, the VFW, the American Legion, the Viet Nam Veterans of America, the Military order of the Purple Heart, AMVETS, Marine Corps League, Former POW's, Navy WAVES Association, Paralyzed Veterans of America, and Jewish American War Vets, before the changes were implemented?

Only the U.S. Congress can ask these questions to the leadership of the Department of Veteran Affairs. Just as medical personnel must probe to find the roots or causes of disease, in the same way, Congress must use its skills to probe the weaknesses in these changes.

Possible negative impact of managed care on the Veterans' Healthcare System

The Veterans Health Administration, under the direction of the Undersecretary of Health has formulated, planned, and is implementing a "Prescription for Change" which includes Mission, Vision, and Strategy goals.

The mission of the Veterans Healthcare System is to "service the needs of America's veterans by providing primary care, specialized care and related medical and social support services. To accomplish this mission, VHA needs to be a comprehensive, integrated Healthcare System that provides excellence in healthcare values, excellence in service as defined by its customers, and excellence in education and research, and needs to be an organization characterized by exceptional accountability and by being an employer of choice." (Veterans Health System mission statement)

The mission statement of the VHA provides an in depth view of the "Prescription for Change".

This "Change" really is not a change. The VA has always provided "Primary Care, once known as Ambulatory Care. Specialized care and related medical and social support services have always been available to the veterans of this country."

So what has changed? The only changes are the amount of funding — which has decreased — and the concept that managed care can be applied to the VA Healthcare System to contain cost.

What is Managed Care? Managed Care can be defined in many ways, but two recognized definitions are:

"An integrated system of health care providers and facilities designed to care for a group of people in a graphically defined area who are in all phases of health, through activities ranging from health promotion for working adults to hospice care for the terminally ill." (Rogers, et al, 1994)

"A patient and physician driven system organized to provide the appropriate level of care in the clinically effective setting, using the most cost efficient methods." (VISN 1 Strategic Plan)

The Undersecretary of Health commissioned the Management Decision and Research Center to formulate a "Summary for Transferring Managed Care Principles to VHA."

The MDRC report was published in august 1996. The Undersecretary armed with this report and his considerable knowledge and experience in managed care, concluded this was the direction in which the VHA should face for the future.

Questions that Congress should ask:

1. What is the present population that uses the Veteran Healthcare System?

2. Do the current concepts of managed care fit the current population of veterans being served in the VA Health System today?

The VA Healthcare System has a glorious history of serving a unique and honorable population of men and women who have sustained physical and emotional injuries while in military service defending this nation's shores and policies. A grateful nation, promising quality health care to the brave men and women, henceforth adopted the Veterans Administration. This system has provided quality care for many years to our veterans. What services did the old VA provide?

Outpatient care (primary care)

Specialized care

Medical support

Social services support

Chronic mental illness

Blind rehabilitation

Spinal cord injury

CDRP

End stage renal disease

Nursing home care unit

Geriatrics outpatient clinics

Infectious disease clinics

The VA Healthcare System has always cared for a population who is the "sickest of the sick": these are disabled and/or indigent patients who experience poor health. They are unable to obtain adequate health insurance at a reasonable rate. The VA is their "safety net" for healthcare.

Managed Care serves an average of only 10 - 20% adverse risk patients. This is exactly the opposite of the Veterans Healthcare System, where the number of adverse risk patients served is 80 - 90%! It is yet to be demonstrated that such a group can receive comprehensive health care at a rate four to five times that of a conventional capitated delivery system. In fact United Healthcare, one of the nation's largest health maintenance organizations, said "it would take a $900 million charge in its second quarter, in part to abandon unprofitable Medicare plans."

How did a system that provided quality healthcare to our veterans get to this point? Under the present VA leadership, data that didn't appreciate the current veteran population as adverse risk was reviewed. The assumption was made that it was the right plan. Then in 1995 the VA responded by mandating a transition from hospital-based specialist care to an outpatient primary care based system adopting the principles of managed care. In 1997 this transition was further implemented by VERA funding, completing the transition to fixed price contracting with congress.

Unfortunately, the very nature of the VA-covered population is radically different from any other fixed price-contracting model in existence in the US today.

Having said the above, how have the VISNs, especially VISN1, responded to the changes and how are the hospitals within the VISNs structured to make the transition without effectively compromising quality healthcare to the veterans?

In the process of proceeding toward managed care, approximately 174 hospitals were assigned to one of 22 VISNs. The VISNs' mission was to oversee the transformation of the VA Healthcare System into a managed care system.

What questions should Congress ask?

1. Are these goals being met within each VISN?

2. Has each VISN director formulated a plan that is benefiting the current veteran population?

3. Are the cutbacks realistic or have they been detrimental to our country's veterans?

4. How can it be claimed that "90% of patients rated the VA as very good or excellent in the light of questions that have been asked about services or contradictory reports, such as "What's behind those satisfaction surveys?" as reported in business and health magazine, a prominent industry publication? (August 1997, page 29)

Instead, another layer of management was created above the management team already in place at the hospital level. Those management teams are still in place, and the positions were refilled as the VISN elevated individuals to that level. The VA budget was decreasing as this new structure of management was being created. Funds were appropriated from congress to provide ten (10) new positions at the VISN management team level. This could be an unnecessary and wasteful expenditure on managerial staffing.

VA New England Healthcare System -- VISN 1

The mission: "to fulfill a grateful nations commitment to its veterans, we will deliver compr quality healthcare that meets patient needs through clinical care, education, and research and the Department of Defense."

In October 1997, the VISN 1 Director published the Strategic Plan for 1998 to 2003. "Jou Change in New England". The Director stated," within the VA New England Healthcare Sy change process will be guided by the explicit concepts and principles interwoven throughout the Vi Change, the Prescription of Change, the Journey of Change and the VA New England Hea lthcar Strategic Plan."

His strongest statement was, "First and foremost is that any change must maintain or enhance the quality of our medical care and services." (Strategic Plan)

What questions should Congress ask?

1. Are the changes maintaining the quality of care and services for our countries veterans?

2. Are they enhancing the care and services of veterans? If so, what measurable benefits have occurred?

3. Has the improvement to a single state's facility in any way negatively impacted facili neighboring states?

The VISN 1 Director, in the process of consolidating Managed Care in New England, actually reduced the medical staffing of facilities in the Far North Sub-Region and the Northern Sub-Region. This hurt veterans in these Sub-Regions by forcing them make long and tiring trips to Boston for treatment that they should have been able to receive locally. As an example, since February 1998, from the Department of Neurology at VAMC Togus, Maine, 376 veterans were compelled to travel from cities and towns as far away as Upper Frenchville, Maine to Jamaica Plains VA in Boston -- a 858 mile round trip journey in two days for a routine consultation that averaged less than 30 minutes!

Togus VAMC, a barometer for all Veteran Healthcare?

Having been a healthcare professional for 18 years, 10 of those years at Togus, I have observed a steady decline in the amount of professional services for veterans. The root of this decline can be traced primarily to consolidation of services and sharp reduction of funding.

Decline in Clinical Staff at Togus.

	1995	Present	Percent Change
Surgeons	12	9	-25%
Internist	22	16	-28%
Psychiatrists	12	7	-42%
Total Physicians Lost	46	31	-33%
Nurses	276	226	-18%
Physician Assistants	12	7	-42%

Loss in Clinical Services since 1995

Vascular Surgery

Dermatology

Physiatry

Inpatient PTSD Program

Inpatient Chemical Dependency Program

Inpatient Detox Program (planned)

Angiography

Therapeutic Nuclear Medicine

Sexual Therapist

Pre-Operative Consultation Service

Accessibility

A new patient entering Primary Care Clinic will typically wait 2 to 3 months to see a physician.

Follow-up clinic visits are double and triple-booked.

Appointment times are shorter and patients wait longer for scheduled appointments.

In summary, the Medical and Surgical Staff at Togus VAMC seek restoration of staffing and serv to levels which assure excellent and comprehensive care for our patients. We seek a renewed environ at Togus that listens to and values our opinions in the strategic planning of clinical services. Without these improvements, we cannot provide the care our patients deserve and expect, nor can we uphold the mission our institution so proudly proclaims to them. (The above summary and preceding paragraphs were signed and approved by 43 physicians and physician assistants at Togus.)

SUMMARY

We have come here today because a promise that was made by our government to provide quality healthcare to all veterans past, present and future. That promise is once again about to be tarnished.

When we were called upon to serve, we did so — whether in time of peace or in times of conflict. Our response was with honor and loyalty to our Country. We trusted in our government to do what was necessary to protect our country and her allies. WE KEPT OUR PROMISE, now it is time for our Government to keep its promise to the men and women who served.

Let there be no more empty promises, no more speeches or data seeking missions. The time has come for the truth, it is time for keeping promise agreed upon. Let there be no more changes, additions, or compromises. Health care is not an issue to be exploited by entrepreneurs, elected officials or individuals trying to make spotlighted career moves at the expense of others illnesses. Quality healthcare to the millions of Veterans who have served this great Nation is a promise that must not be broken. Every state in this Union deserves at least ONE fully staffed Veterans Hospital providing ALL required services to the Veterans of that state. Dr. Roger Bone wrote, "we have allowed the bureaucrats and administrators to change the goals of medicine dangerously with the ruse that medicine is too expensive." The time to correct that error has come and rightfully, it should start here with Congress, where it began. Remove medicine as an issue from administrators' and politicians' agendas that would be used to balance budgets. Fund the Veterans Healthcare System to provide the ultimate in quality healthcare, than plan for the future by expanding this system to be bring in patients and families from Medicare, the Department of Defense, and State Government employees.

The erosion of the Veteran Healthcare System must stop here. We must spread the word to every Veteran across the United States, that as long as ONE American man or women still serves this great nation in uniform, the Veterans' Healthcare System must provide the ultimate in quality healthcare. Thank You and God bless you all.

References to document referrals in the text

Management Decision and Research Center "Transferring Managed Care Principles to VHA"; Published August 1996 by VA Health Service Research & Development Service.

VA New England Healthcare System "Strategic Plan FY 1998 - FY 2003", published October 31, 1997.

Veterans Equitable Resource Allocation (VERA), Department of Veterans Affairs, published April 1998.

The American Journal of Medicine, "My Hope for Medicine", by Roger C. Bone, MD, Ph.D., Chicago, Illinois, published Volume 102, March 1997.

Business & Health Magazine "What's behind those satisfaction surveys?" by Shelly Reese, August 1997.

Memorandum to Maine State Congressional Delegation, "Deterioration of Clinical Service," by Medical and Surgical Staff Togus VAMC, dated August 14,1997.

Department of Veterans Affairs, Togus, Maine, "Togus Shuttle", schedule for veterans traveling to the Boston VA Area.

Mr. SHAYS. Forty-three out of how many?

Mr. BACHMAN. I think there's 48, sir.

Mr. SHAYS. Mr. Williams.

Mr. WILLIAMS. Chairman Shays, members of the House Subcommittee on Human Resources, I would like to thank you all, and particularly Congressman Tom Allen of Maine, for this opportunity to appear here today and present my concerns and those of many other veterans and healthcare professionals with whom I have had contact as the past State department commander of Military Order of the Purple Heart.

I would like to tell you briefly if I could about a few of these veterans. Maine veterans are a unique group, often living on the edge of poverty, fiercely independent, and frequently living in remote areas that are oftentimes hours from the nearest VA facility, in a State that has little or no public transportation. These veterans now present to the Veterans' Administration with multiple medical problems, no insurance, no employment, and no other health care provider. The people who go to the Togus VA facility are generally there because they have no other place to go, and it is their place of last resort.

They have strong ties to their families and their communities, and going to Togus is a very, very difficult decision for these independent Yankees. Traveling to Togus is often a trial, especially in the winter months for those aging veterans and for those with serious medical conditions. Many of those trips begin before light and end well after dark, frequently after tiring hours in Togus or beyond in Massachusetts.

There are also those of us who go there because of our war-incurred illnesses and injuries and we are not able to get insurance of any kind. Many of us are unable to obtain or maintain a regular job. I have provided much more detail, in a 32-page written document containing testimony which concentrates on the problems experienced by veterans in terms of access to healthcare, level of healthcare locally available, clinic waiting times, distances traveled. I am going to skip a lot of this, sir, so we can get through this.

But it is frequently for a 20-minute appointment, a veteran from Maine will have to drive 6 or 8 hours to get to the Togus facility, take a 4-hour bus ride to Jamaica Plains, then wait overnight to get a matching schedule to another hospital, go to that hospital for a 20-minute appointment. Unless that appointment falls right, stay overnight at that facility, to go back to Jamaica Plains, to go back to Maine, and then have to drive hours back to their home.

I would like to tell you briefly about one particular veteran, but I would like to mention that the State of Connecticut is a fine State. The county I live in in Maine, Piscataquis, is geographically the same size as the whole State of Connecticut. It takes me about 3 hours on a nice sunny day to make it down to the Togus VA facility. We don't have a lot of nice bright sunny days. A lot of the days we have snow storms, and the roads are covered by ice. It takes 6 or 8 hours just to get to the VA facility there. Compounding that——

Mr. SHAYS. If you would just yield a second. So that I am understanding why you are telling me this. Are you telling me this be-

cause you want a guarantee that at least when you make this trip you get the best service possible? Are you telling me this because you feel you need more outpatient clinics or something closer? I just need to know. I mean I need to feel your pain, but I need to know what that tells me in the end.

Mr. WILLIAMS. I think I am telling you, sir, that we had an excellent facility at the Togus VA Hospital, and that yes, the outpatient clinics are good, but there are a lot of veterans in our State that need specialized care. That care needs to be provided in the State of Maine and not in another State.

Mr. SHAYS. So are you suggesting that maybe some of these facilities be at private hospitals and public hospitals as opposed to the VA facility?

Mr. WILLIAMS. Sir, they were available at the VA facility until we have gone through all of these cuts. We were able until the last 2 years or so to go to Togus as a full-service hospital and receive those guaranteed benefits. That is no longer true.

Mr. SHAYS. So your argument is that even at Togus you will still have to travel, but not as much.

Mr. WILLIAMS. Yes.

Mr. SHAYS. OK. Thank you.

Mr. WILLIAMS. I would like to give you a case here. I want to just give you a quick overview of it. Again, it's in the written testimony. This is a personal friend, a gentleman by the name of Larry Arthur Preston, a fellow Vietnam veteran.

On the morning of October 3, Larry was hit by shrapnel from an enemy mortar round. At that point, one of his legs was blown off initially. He suffered over 200 shrapnel wounds throughout his body. In 1985, as a result of his wounds and further medical complications, Larry lost his remaining leg. He is another proud Mainer. Larry now lives a quiet life in rural seacoast Maine asking for nothing special at all. He rides around on an old beat-up wheelchair that is genuinely a disgrace, without even a seat cushion to sit on because he won't go to the VA and ask for one.

In May of this year, he went down to visit his sister in Massachusetts. He had some discomfort in his right buttock that he was concerned about. So he went to his sister and she looked at him and she described to me a triangular spongy mass about the size of a tennis ball. She advised him to immediately call Togus and request that he get in there as soon as possible. That didn't happen. He couldn't get in, and they were talking about an appointment months down the road. So instead, on her suggestion, he went into the urgent care clinic. In the appointments that would follow on an irregular non-emergency basis, medical samples were taken from a growth that was in his buttocks but were never tested for cancer. Invasive surgery was done to explore the growth, still before any tests were done, to see if there was cancer in that tissue. It wasn't until after the invasive surgery that they discovered that in fact the growth was cancerous. I have been told by physicians outside the VA this never should have happened.

As a lay person, I can only attribute the apparent gross errors that occurred, outlined in my 30-page written testimony here, to the fact that the doctors at Togus are completely overwhelmed by

the sheer number of patients seen each day and very limited times with each patient.

Recently I had a veteran come to me with multiple medical problems. He told me that his doctor at Togus said, "It's good to see you. We've got less than 20 minutes left. I can only talk to you about one problem. You tell me which one problem we can talk about today."

My complete testimony goes on to tell you a lot about Larry. I will tell you that he finally made it down to Boston after battling his way down there. After the tumor board there, Togus had requested that he go to a specialized care facility. He was sent to Boston anyway. He got there and for 2 weeks the Boston facility and the Togus facility fought over where his x rays and his CAT scans were because they couldn't locate them and they didn't want to redo the tests as neither facility wanted to pay to have them redone. When it was finally done, his one tumor in his right buttock turned out to be that he now had an additional three tumors in that buttock, four tumors in his left lung, and another four in his right.

Because of numerous administrative delays and medical foulups, Larry did not begin radiation until nearly 5 months after he was first seen in Togus. That was nearly a month after he first requested treatment. So we are talking 6 months here.

Larry Preston is just one example of the deep cuts into the VA budget that we're seeing in Togus. He is having to pay with his life. His cancer has staged to a level where it is just a matter of time. Had he been seen quickly, treated appropriately, and referred to one of our fine cancer centers, I am told that Larry Preston would have had a real good chance of living. Larry Preston lost his legs as a result of his battles in the jungles of Vietnam. He will lose his life as a result of his battles for appropriate medical care with an understaffed and underfunded Veterans' Administration Hospital at Togus, Maine. Thank you.

[The prepared statement of Mr. Williams follows:]

Testimony of

Neal A. Williams , disabled Veteran

before a hearing of the

House Committee on Government Reform and Oversight

concerning VA Health Care Services in Maine

25 September 1998

Chairman Shays, Ranking Republican Member Gilman, Ranking Minority Member Towns, members of the House Committee on Government Reform and Oversight, I am Neal A. Williams, a disabled veteran, a life member of Military Order of the Purple Heart (MOPH), Paralyzed Veterans of America (PVA), Vietnam Veterans of America (VVA), Disabled American Veterans (DAV), Veterans of Foreign Wars (VFW), American Veterans (AMVETS) and annual member of the American Legion . I thank you all and in particular Congressman Tom Allen of Maine for this opportunity to appear here today to present my concerns and those of many other Veterans and health care professionals with whom I have had contact as Past State Commander, Department of Maine MOPH and as a volunteer advocate for MOPH

assisting veterans filing benefits claims with the Veterans Administration through our full-time accredited veterans advocate at the VA Regional Center in Togus, Maine.

Maine Veterans are a unique group, often living on the edge of poverty, fiercely independent and frequently living in remote areas that are oftentimes hours from the nearest VA facility in a state that has little or no public transportation. These Veterans are men and women who served their country when called upon and now present to the Veterans Administration with multiple medical problems, no insurance, no employment and no other health care provider. The people who go to the Togus VA facility are there generally because they have no other place to go and it is a place of last resort. They have strong ties to their families and their communities and going to Togus to ask for medical help is a very difficult decision. Traveling to Togus is often a trial, especially in the winter months for those aging veterans, and for those with serious medical conditions. Many of those trips begin before light and end well after dark, frequently after tiring hours at Togus or beyond in Massachusetts. In terms of time on the road that would be equivalent of asking you to travel from Washington to Boston to receive any specialized medical care you might need. There are also those of us who go there because of our war incurred injuries

and illnesses, we are not able to get insurance and many of us are unable to obtain or maintain a regular job.

I will concentrate much of what I have to say on the problems experienced by Veterans in terms of access to health care, level of health care locally available, clinic waiting times and distances traveled to receive care. I will also point out cases where Veterans are suffering needlessly and even dying as a result of not being able to receive or access in a timely manner adequate health care.

While the local Veterans Administration staff disputes the numbers, a name by name list of physicians reveals a 32 percent reduction in physicians from 1995 to 1997. This statistic does not include current staffing levels which are even lower. This decreased staffing is based on what VA officials claim is a decreasing Veterans population. Consequently, they argue there is a decreasing need for services. An independent management review of the Department of Veterans Affairs by The National Academy of Public Administration indicates in a draft report obtained by the Army Times the following circumstances. While the national Veterans population has decreased by approximately 5 percent, the number of Veterans served and compensated for disability by the VA has increased by 3 percent during the same period. It is important to point out too that the Veteran population

in Maine has been increasing at the same time. As a result of these staffing cuts, many of Maines' Veterans who have to drive over six hours one way to reach the Togus VA facility now have to take a van and ride an additional four hours to go to Jamaica Plains VAMC in Boston to receive treatment previously available to them in Maine or to transfer to another van to go to the hospital where they have an appointment in the VISN 1 area. The van leaves the Togus facility at 7:20 A.M. and to get a seat you must be present at 7:00 A.M.. Assuming everything goes according to schedule, and there are no traffic delays or accidents, you should arrive between 11:30 A.M. and noon. Just when everyone at Boston is going to lunch. ***IF*** your appointment is at Jamaica Plains VAMC and ***IF*** it is after the arrival time you can be seen for a twenty minute appointment ***IF*** Jamaica Plains VAMC has a record of the appointment. Frequently I have had reports of Veterans making this lengthy trip only to find Boston has no record of the Veterans' appointment. All this is also assuming the Veteran is able to complete any required administrative paperwork, go to the pharmacy, prosthetics or wherever the Doctor sends the veteran to and then make it back to the van by 3:00 p.m. for the3:30 p.m. departure to arrive back at the Togus VAMC in Maine at approximately 7:00 p.m.. The Veteran then has to face the several hour drive home.

This, ladies and gentlemen, is a best case scenario. I have had several Veterans come to me upset that they were not able to complete their appointment, a stop at the pharmacy and stop at the travel section in time to make the return connection. Actually there are many times when a Veteran will have an appointment at another facility, the West Roxbury VAMC for example . If this is the case, the Veteran will have to add one and possibly even two additional days of travel with lodging in West Roxbury and Jamaica Plains for what is commonly a twenty minute appointment. A quick review of the attached 1998 Veterans Affairs Shuttle Guide, New England Region, dated 1 April 1998, will clearly demonstrate the difficulties encountered when trying to travel from Maine to appointments at other facilities within VISN 1. This lengthy, and even cruel travel schedule is a harsh and unreasonable burden on our aging veterans population especially those from WWII, who for the most part are in their seventies and eighties and oftentimes simply getting to Togus is a torturous trip. It seems those who are suffering the worst are those who are being required to travel the farthest for the specialized care they require. Here are just a few of the many cases I have personally involved in. Recently, the current State Commander for MOPH, a combat wounded WWII veteran had to travel to Jamaica Plains to see a neurologist because one had

not been hired at Togus in over a year. That fact is especially interesting since Togus VAMC is the only facility with a qualified Spinal Cord Injury Clinic outside of West Roxbury within VISN 1. While in Jamaica Plains, or on the tightly crowded van, Commander Lafrance contracted an illness so severe his local hospital put him in quarantine for a week after his return home. The Lewiston Maine Sun Journal, April 26, 1998, quotes Commander Lafrance as saying, "When we were called in, they said they were going to take care of us. We're not getting the care that they promised....The doctors in Togus are good doctors, but they do not have enough of them." This sentiment seems universal among the Maine Veterans population. Generally, reports I have received indicate Veterans are relatively happy with the care that they get from most of the health care professionals at Togus most of the time. However, with more and more pressure on those medical professionals to see more patients as the pressure increases so does the chance that mistakes will be made. A case in point is Larry Arthur Preston, a friend and fellow Vietnam Veteran. Larry served as a radio operator for a forward observer in the Republic of Vietnam, relaying back the messages to the artillery when the infantrymen they accompanied in the field needed artillery fire support. On the morning of October 3, 1971, Larry and a small number of

troops were waiting to be the last extracted from the jungle clearing after a search and destroy operation. There had been little contact with the enemy to that point and everyone was pretty relaxed as they provided security at the landing zone for the last soldiers to leave and awaited the helicopters that were coming to get them. Preston heard the first two explosions, but thought nothing of it because some of the infantry had been firing M-79 grenades into the tree line for practice. He did not hear the third explosion but felt himself being pushed backward and over and he felt intense heat as if the sun were directly there in front of him. He describes falling over backwards and seeing blood spraying in two different directions still not realizing he had been hit. An enemy mortar round had landed within just a few feet of him and Larry's life was changed forever. One of his legs had been blown off and he had over 200 separate shrapnel wounds. Only the fast actions of a medic saved Larry's life minutes after the round struck at 10:41 a.m. that October morning. For the next two years Larry Preston spent most of his time in Valley Forge Army Hospital undergoing many more operations and several more amputations until the most damaged flesh was removed. In 1985 as a result of his wounds and further medical complications Larry Preston lost his remaining leg. Larry lives a quiet life in rural Maine asking for nothing special.

He rides around in an old beat up wheel chair that is a disgrace without even a seat cushion because he has not asked the VA for a new one. He tells me he thought most of his suffering had ended and that he had suffered enough for a principle called freedom. On 31 May 1997, Larry was visiting his sister, a nurse, in Massachusetts and he had a sore spot on his right buttock that he was concerned about. He asked his sister to check it and she described a triangular spongy mass approximately the size of a tennis ball in his right buttock. On her advice he immediately began to call Togus for an immediate appointment, but when he received little response he went into the urgent care clinic instead. The urgent care clinic and VA records indicated a melon-size mass in the right buttock without any antecedent history. Preston and his sister dispute this statement saying initially the mass was the size of a tennis ball. At the time he was seen, the records indicate the mass appeared slightly erythematous and a needle aspiration was done. The attending physician suspected possible infection, but it revealed only "old blood". A very revealing statement in the VA records states, "The specimen was not sent for cytology." A follow-up appointment was scheduled for a month later. The stories of the VA and the Veteran describing these circumstances are quite different. Preston, who claims the mass was the size of

a tennis ball when he initially went into be seen claimed it grew to melon size in the month he had to wait to be seen again. He still maintains that to be the case. The VA report alleges that there was "no significant change in consistency or size of the lesion" having written it up as having been melon-sized in a subsequent report of the initial visit. After his second visit, it was still unclear what was going on. Still a test for cancer cells was not conducted. There was some speculation about his condition with consideration being given to inflammatory vs. hematoma vs. mass lesion. On 17 July 1997, Preston was admitted to the Togus Veterans Administration hospital in Togus for exploratory surgery on the yet unidentified mass. A test for cancer cells had still not been conducted. What had been a spongy mass the size of a tennis ball, according to Preston, at the end of May had grown to a mass he describes as grapefruit size and the VA surgical report describes as being 18 X 16 X 7 centimeters in size by 17 July when it was removed. A subsequent report revealed a leiomyosarcoma with moderate mitotic activity and probable positive margins. According to all the medical professionals I have spoken with, the "old blood" that was drawn from the mass should have been tested for more than signs of infection. Common medical practice, I am told, would also dictate that testing be done for presence of cancer cells

also and in his subsequent visit the same test should have been conducted even prior to considering exploratory surgery. As a lay person I can only attribute this apparently gross error to the fact that the doctors at Togus are completely overwhelmed by the numbers of patients they are expected to see each day with very limited time with each and the clerical staff that used to be present to support the doctors is just no longer present. Preston recalls, after discovering he had cancer, talking with a Dr. Dorsk at Togus who suggested he should go to Dana Farber Cancer Hospital or to Massachusetts General Hospital in Boston as they were best equipped to handle his difficult and aggressive form of cancer but, the doctor went on to explain the VA would only send him there if he had a third party insurer such as Medicare or private health insurance. Preston explained that he did not have the coverage. After having checked on it, he discovered he could not afford the over $900.00 a month premium the Blue Cross/Blue Shield would require of a bilateral amputee with other medical problems. The doctor encouraged him again to get medical coverage under Medicare if he could. That view is completely consistent with a VA report concerning Preston that says, "The question of re-operation was discussed with Dr. Bossart, in an attempt to achieve clear surgical margins. Dr. Hegener of Radiation Therapy suggested that consideration at

the time of surgery be made for possible brachytherapy or interstitial therapy or even intraoperative electron beam therapy. Further work up to rule out metastatic disease needs to be done including a chest CT and a bone scan. The consensus of the meeting was that the patient needed to be seen in a specialized sarcoma program for consideration of surgery and/or radiation therapy, possibly at Mass General..." While the VA Doctors recognized the need for Preston to be treated at a facility such as Dana Farber or Massachusetts General, the administrative people apparently were the ones making life and death decisions for Larry Preston based on his ability to provide a third party insurer to pay. It was not until 2 September 1997, over a month and a half later, that Larry was able to get an appointment scheduled with a Dr. Johnson at the Jamaica Plains VA in Boston. Preston took the VA van to Boston but had a great deal of difficulty as the van was not handicapped accessible. Upon arriving at the van, he had to get out of his wheelchair onto the ground so other veterans could lift his chair into the van and then assist him in climbing in the van. The same thing happened at the other end of the line, with Preston, a combat wounded Veteran, not even being afforded the mobility options guaranteed him by the American With Disabilities Act. What a way to treat a Veteran who has sacrificed so much for his country. Upon arrival he

discovered that Boston said they could not treat him because they had no x-rays or CT scans that were to have been forwarded from the Togus VA facility. Preston had to wait another two weeks while the two VA facilities argued one with another over who had his x-rays and CT scans. He was not allowed to stay in the hospital while he waited but had to stay in guest housing. At one point Preston called the VA Togus facility and requested they provide copies of the x-rays and CT scans to his wife. She was going to make arraignments to have them delivered to Preston in Boston, but the VA Togus facility called her in a couple of days saying they could not find the films. Two weeks later it was decided by someone to reprint the original x-ray and CT scan which appeared in Boston and apparently more CT scans were done on Prestons' chest, abdomen, and buttocks at the Boston VA facility as well. He was told that the cancer had by this time spread and he in addition to the original tumor found in the right buttock he now had an additional three tumors in that buttock, four tumors in the left lung and another four tumors in the right lung. At that point Larry was scheduled to undergo a regime of 20 Radiation Therapy treatments there in Boston while his family and support network remained in Maine. This radiation treatment however, did not begin until 18 September nearly four and one half months after he had fought his way

into the Togus VA facility and demanded treatment. On 16 October his treatments ended and his wife with a friend as a co-driver drove to Boston to pick him up and return him to his home in Maine, a nearly four hour drive that he describes as sheer torture. This because Togus had eliminated it's nuclear medicine department and was not willing to pay for the level of care the facilities own physicians were recommending. Larry Preston is a victim of deep cuts into the VA budget as a result of the Balanced Budget Act and is having to pay with his life. His cancer has staged to a level where it is a matter of time before he dies. Had he been seen quickly, treated appropriately and referred to one of our fine Boston cancer centers Larry Preston would have had a chance to live. Larry Preston lost his legs as a consequence of fighting an armed enemy of the United States now he will lose his life in his battle to receive the necessary health care he needed and deserved.

Much has been made of the waiting times for appointments. Veterans like Larry Preston are suffering as a result of there not being enough physicians to provide the needed medical care at the VA or money to get it outside the VA system. Letters to the editor in various Maine newspapers complain of the lengthening waiting times. As U.S. Representative Sue Kelly of New York was reported in the 24

September 1997, Poughkeepsie (NY) Journal, as saying in a letter to Senator Arlen Specter (R) Pa., Chairman of the Veterans' Affairs Committee, "there has been "stonewalling" at the "highest levels of the VA" in responding to concerns raised by members of the New York congressional delegation..." I posit that the same thing is happening in Maine and continues to happen. The VAMC Togus, and at a minimum the VISN 1 level and Veterans Administration are blowing smoke at our Congressional Delegation. I think they have finally seen through the smoke screen. For example, in a 20-21 June 1998 article in The Bangor Daily News the following appeared: "In February, Togus administrators announced waiting times had been cut in half... critical staff positions in neurology, psychology and other departments had been filled... Since September, according to VA reports, the hospital has cut waiting times for appointments to 10 days, three times better than the VA standard of 30 days..." Again, we see the VA telling half truths and "stonewalling". Yes, some of the positions were filled but in at least one case it was filled for less than forty eight hours and the physicians left refusing to work in an environment where they were not being allowed to provide the level of care to their patients they thought medically appropriate. As of this date, to the best of my knowledge Togus VA does not have a full-time neurologist

hired and the neurosurgeon is retiring shortly. Morale at the facility seems to me to be at an all time low. Many medical professionals have been taking early retirement to get out of the situation. Recently a Doctor John Meyers resigned as the charge physician at the Bangor Outpatient Clinic. I quote the Doctor in an e-mail he sent which states, " My ethical and legal responsibilities to Bangor veteran patients have been compromised by lack of support from Dr. Wm. Anderson. I actually believed the goals of "continuity of care" and "the veteran comes first" were real! All I hear are excuses about the VA system; I believe the individual administrative people at Togus are incompetent. The new production line approach is unlikely to foster close communication of community-based clinic's professional-veteran relationships." Just days before coming to Washington to present this testimony four pharmacists resigned over the under staffing, working conditions, and the lack of response to their professional concerns relative to Veteran care by the administration at Togus VAMC. All of these medical professionals are good people who have been immediately re-employed in outside pharmacies. I have been approached by many many veterans about the waiting times for clinics at the Togus VAMC. I will point to one only as an example of what continues to be an ongoing and apparently worsening problem at the Togus VAMC. I will call

this individual Roger. Roger is a veteran who worked for the Veterans Administration for years and recently retired with many years of faithful service to America's Veterans. Roger, having difficulties with a thirty percent service connected a heart condition, began the process of calling requesting an appointment to be seen by a cardiologist for follow up on his condition. On 15 May 1996 records show he had a stress test and was able to get the results on 13 November 1996 from his Cardiologist with a follow-up appointment on 19 Mar 1997. On 23 July 1997, Roger again was able to get a 20 minute appointment with Doctor Legum and a stress test was ordered as a result of the appointment. That test was scheduled for 2 October 1997, but was canceled by J. Dawn Duggins, a ward clerk, without further explanation in the records. A later appointment with Doctor Legum, scheduled for 10 December 1997, was canceled by William Boutin, another ward clerk, again without recorded explanation. After numerous calls and persistence on Rogers' part he was able to get an appointment and at that appointment received the stress test on the 18th of December, a test which had been ordered by his Doctor in July. Roger was given a 3 June 1998 appointment, six months later, with his cardiologist to get the results of the stress test and to find out what the status of his heart might be. After anxiously waiting to find out what the current condition

of his heart was he again received word that his appointment with his cardiologist had been canceled. He would now be seen by a new cardiologist on 21 August 1998. It would have been just over a year since Roger, service-connected Veteran with a heart condition would have received the news of his latest stress test; however the appointment was again canceled without any explanation. Roger is now scheduled to see a new cardiologist, by whom he has not been treated previously, on 20 November 1998, if the appointment is not rescheduled. All we can hope for is that there will be no major change for the worse in his heart condition. And what about Gerald Myrick, a veteran, past State Commander of AMVETS, who had for some time complained of morning heart spells. These heart related complaints appear in the Veterans medical records in early 1997. On 17 December 1997, after continuing treatment his attending physician John L. Myers, MD., ordered an event monitor from the Togus VAMC believing that Myrick's "morning spells were suggestive of symptomatic bradycardia and he was considering ventricular bigeminy, heart block, etc." A progress note in the records provided by Myrick dated 17 March 1998, indicated, "the event monitor was unavailable from Togus." In a letter from Myrick he says, "I have continued to have problems which have gotten worse. Finally, on August 6, 1998 I went to Togus where I had a series of scans and X-rays.

On September 15 1998 I received the results of these tests. The Doctor at the clinic in Bangor tells me that I have two arteries leading into the heart that are blocked.... If these tests had been done in a reasonable time, I have to wonder if this problem might have not gotten to this extreme. The Doctor has prescribed medication for me. At this time I am waiting for this to come from Togus. I have been told to expect a delay in receiving this due to the fact that there have been four pharmacists that have quit". These cases are not isolated ones but examples of the long waits most veterans encounter when trying to get to see secondary or specialized care physicians. Each time a case like this has been cited by a Veterans Organization, Dr. Arnold Brown, Chief of Staff at the Togus VAMC, has aggressively insured that the individual veteran will get priority treatment. He has routinely called the Chief of the affected medical service and directed that Chief to get the Veteran in to see a Doctor, giving that Veteran the highest possible priority. Dr. Brown then reports to the Veterans Organization making the request and to the Center Director that the problem has been resolved. That is not really true. The individual Veteran has received priority treatment, that is true, but every other Veteran on the waiting list will be pushed back at least one patient and the waiting lists still remain a problem. Again from the Bangor

Daily News, Veterans need local health care, 30 September 1997, "The VA administrators have become very adept as using semantics to cloud or confuse an issue. One might even believe their intent was to mislead. Often times saying one thing but in the end meaning something quite different." At the same time the administration will point to the Veteran who has been bounced to the head of the line and say something to the effect, "See what a wonderful job we are doing for Maine Veterans." Certainly that Veteran will be happy after having received such treatment and gladly reports this fact to his or her respective Veterans Organization.

In VHA directive 98-023 attachment C 4 (3) b dated 17 April 1998, a document signed by Kenneth W Kizer, MD., there is a NOTE: which says, " Situations may arise when due to resource constraints, VA must delay the provision of non-emergent care (e.g., delays in clinic appointments), or provide care in a limited number of locations that may not be convenient to an enrolled veteran. In those instances, a veteran with other healthcare coverage may choose to seek care through those sources instead." Since the VA is, for most of the Veterans served, the only source of medical care available to them I wonder where the "other healthcare insurance" is supposed to come from. In my case I was at one time given an opportunity to get Medicare insurance because of my

disabilities. Because I was receiving such excellent care from the VA and I felt my disabilities were solely because of my military service, I refused that coverage. Now many years later I discover I should have accepted that coverage to receive the best level of healthcare. If I were to enroll at this time I would have to pay all of the back premiums and penalties that would amount to more than my total net worth to achieve the needed additional coverage. While there may be third party insurers that may provide coverage for totally disabled Veterans the cost of that insurance is so prohibitively high they are, like Larry Preston, not able to afford it. What about the hundreds of Veterans like Roger who keep getting appointments canceled and new appointments being made? Are those the ones the VA administrators are looking at when they tell the Maine Delegation and the press that Veterans are being seen within ten days?

If a 100 percent service connected disabled Veteran were to have one or all of his teeth pulled today it would be eighteen months or longer before the Veterans name would even come up on the waiting list for the dentures or a partial to be fitted and made. It would have taken months to get through the waiting list to have the extractions done because the facility no longer has an oral surgeon and has to wait for one to come from Boston one day a week to perform needed dental

surgery. And what about preventative medicine, (Prevention Index), as is outlined in the VA New England Performance Measures Attachment B, page B-7 to the Strategic Plan FY 1998 - FY 2003, Journey of Change in New England, which says the goal of the VISN is to, "Increase to 90% the proportion of Network patients who rate the quality of VA healthcare better than they would receive from any other healthcare provider" Is this a joke? For example in the Dental department I recently discovered that in order to reduce the waiting list for routine cleaning and exams by a dental hygienist they simply threw away the waiting list. That certainly is an inventive way to reduce a waiting list, just eliminate it completely! There are not enough dental hygienists employed at the VA Togus to begin to take care of the current need. Such preventative care is missing throughout the Togus VA. There are excellent people working at the Togus dental clinic who are just able to have enough time to respond to the emergencies and problems while the routine healthcare issues like preventative medicine are falling to the wayside. An example of this is oral cancers. According to an article in the Bangor Daily News, 20-21 September 1997 between 1987 and 1992 when the figures were kept, there were 3.3 oral cancers discovered each year as a result of routine dental exams. Since the Dental Department has been downsized from five

dentists to two and one half, with one spending half time as the Chief of Service, the practice of oral exams has been dropped as a result of an administrative memo. At this point most discoveries of the oral cancers in Veterans have not come until the cancer is so advanced that the Veteran dies as a result of it. This is something that would have been preventable by the practice of routine preventative medicine. On the positive side for the VA the dead do not complain and their records have been sealed so those of us who would give them voice are not able to access those files. I can however share with you details for some of those still living who have agreed to share that information. As early as 1994, Robert G. Brown, a seventy percent disabled service connected veteran and military retiree had been requesting dental care from the VA. He realized he had problems in his mouth and he believed they were secondary to experimental treatment he allegedly had received in 1944. He alleges that steel rods were inserted in the sinuses of several air crews and the rods were then radiated with radium to "clear out the sinus." This was done at Tindall Air Field, Florida in experiments done to aid flyers who would be flying at high altitudes. On 24 January 1995, a consultation sheet revealed a note from William A. Anderson, MD., who indicates Brown has "no dental eligibility". There is no evidence that any review was made

concerning a condition or conditions secondary to the use of an experimental procedure. Later that year Brown who still suspects there may be dental/oral problems writes a letter to the VA requesting a claim be opened for him for, "dental problems related to my experimental dental procedures...." and for other problems. In a rating decision dated 19 October 1995, Brown was denied eligibility for dental treatment and later states, "there is no evidence of radium treatment in service." Going back over Mr. Brown's appointments from present to 1996 the following information is revealed. Brown apparently had at least nine appointments with his primary care provider or the providers' nurse from January 1996 through 20 March 1998. On 19 May 1998 an unusual growth was finally noted in his mouth by Nurse S. Starrett who saw him on that day. Nurse Starrett having had a recent class on oral cancers made an emergency referral to the dental clinic and a biopsy was performed. The examining dentist correctly identified the growth as a squamous cell carcinoma as later surgical pathology reports would confirm. The Veteran has begun the process of treatment for his oral cancer but according to knowledgeable physicians I have spoken with this Veteran has only about a 50% chance of survival. Had the Veteran been examined sooner successful treatment would have been nearly a foregone conclusion. This is not the fault of a

physician who had seen the patient over and over again during the two years previous to the discovery of the cancer. The Veteran certainly was aware that something was going on as he repeatedly asked for dental care knowing something was wrong in his mouth. This Veteran is suffering and will suffer because there is not enough money in the budget for Togus VAMC to allow the Doctors adequate time to do complete and thorough examinations of patients who are being rushed before them in assembly line fashion. I could go on and on with individual examples of Veterans who have suffered as a result of the balanced budget act which unfairly targets Veterans for a larger cut than other agencies. VERA has had a direct impact on the ability of the VA to provide adequate health care to Northeastern Veterans. Less than forthcoming VA administrators at the Regional, VISN and national levels have been obstructionist in providing the Congress and the public the information regarding impact of these cuts and shifts in funds. Togus has become more and more a clinic while the administration in Boston at the VISN and at Togus assert that a "community Hospital" standard is being maintained. Togus is not able to handle emergent care that in a Veterans population could almost be characterized as routine.

I received a letter, dated 11 September 1998 from Gary Burns, National Service Officer with the DAV concerning a

Veteran who is receiving bills for emergency surgery for which he was eligible, but Togus was not able to provide. Burns, a combat wounded Veteran who entered the US Army in March 1967 and was wounded one Sunday morning in April 1969 when, as one of the first troops on the ground in the Ashau Valley, in Vietnam, a piece shrapnel from a rocket tore the femoral artery out of his leg. He was retired from the US Army in March 1969 and has required numerous surgeries since that time. Gary has served faithfully as a National Service Officer with the DAV since January 1970 in Togus and is the senior National Service Officer now serving with the DAV. In the letter, attached, he describes a WWII Veteran who reported to the Togus VAMC with the sudden onset of "excruciating pain in his right lower extremity". The Veteran was seen by a Dr. Jan Bossart who immediately made arrangements to have the Veteran transferred to a local hospital for emergency surgery. As soon as the Veteran was stabilized, the VA attempted to have him transferred, a four hour or longer trip by ambulance, to the Boston VAMC. The Veteran, who is 77-78 years old, had just had emergency surgery to save his leg and the VA was trying to move this man away from his family two states, to a hospital with a less than admirable reputation among Maine Veterans. Understandably the Veteran chose to stay at the local hospital where he had the support of friends and family

and he trusted the physicians to provide him with the care he needed. It is said that a good deal of a patients recovery is as a result of their psychological well being. What consideration is being given to this when a Veteran is being forced to move three states away from his support network? Attached is the letter from Burns and copies of the bills that the Veteran is receiving because the Togus VAMC could not provide the same care available in the locally available community hospital. Gary Burns, a combat wounded Veteran, a man who has dedicated his whole life since his service in Vietnam to serving other Veterans has expressed his personal discomfort at not having a vascular surgeon at Togus VAMC, knowing that at anytime the artificial femoral artery in his leg could fail. This is not a frivolous concern, it could literally be a life or limb situation for Gary and for the many other Veterans he serves with the same medical concerns who need to have a place to go in an emergency. Yet the administration continues to maintain that Togus is maintaining a community hospital standard. Currently plans are being made to cut an additional $8 million plus dollars from the Togus VA budget. This in response to VERA. To do so would cause even less care to be available to the Veterans of the State of Maine to be provided in this State. Yet the administration continues to talk of availability of services but ignores the

fact that most of those services are only available out of State and out of reach to an aging Veterans population not able or willing to make the long drive to Boston or beyond. The waiting times for these services are months in the future. Travel time and conditions are a VERY real consideration for the Maine Veteran with snow and ice covered roads for a good part of the year. Unlike many states that have an extensive interstate road system the majority of Maine roads are secondary roads which demand slower speeds and many more delays, yet there are veterans who have to travel for hours to reach the VA hospital in Togus for care that is not available in community based outpatient clinics which are few and far between. VA milage charts reveal that Veterans from the following Maine towns have the following one way distances to travel to the Togus VAMC: Eagle Lake 302 miles, Saint Francis 297 miles, Van Burne 271. Clearly these are some of the most distant towns but they clearly demonstrate the need for the Togus VAMC to be a fully staffed hospital able to handle the needs of a population that is spread out over a very large land mass. Geographically the State of Maiis larger than all of the other states in VISN one combined. Just the county I live in, Piscataquis, is larger geographically than the State of Connecticut. With just one hospital to serve such a large area even that hospital, if it were fully staffed, would not

meet the community standard. If that were the case there would not be hospitals located throughout the State as it is today but there would be just one as is done by the VA. Earlier I indicated that the VA administration had not been completely forthcoming with the Congress of the United States, the Governors Office of the State of Maine or the public. An example of this is clearly documented in 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 on 23 July 1998. In that testimony he says, "We obtain, from the local VAMCs, the number of doctors and nurses working at each of the SCI (Spinal Cord Injury) Centers throughout the year. The actual SCI doctor and nurse staffing is only half of what the VA has reported to Congress. We have no idea where the VA comes up with 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." "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 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 the VA maintaining the capacity of its spinal cord dysfunction programs? The answer is no. Does the 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 the VA isn't going (to) follow the will of Congress, Then the Congress must step in again to see that it does." While Mr. Mansfield's testimony has a very narrow focus in terms of the area of health care being provided Veterans across the country it very dramatically illustrates what is happening to the level of health care being provided to Veterans who need more than is available in the outpatient clinics. Because of VERA, Maine is being even harder struck by budgetary cutbacks and thus services that were once available in State are no longer. The invitation sent to speak with you today asked for recommendations. First and foremost the issue of money to the

Veterans Administration has to be addressed. As an agency it has taken cuts under the Clinton Administration that amount to almost twice what other Federal Agencies have. The time to stop this is NOW. The Congress needs to stop the reduction in funds to treat Veterans at a time when they need it more than ever. VERA is shifting funds from Maine to the "sun belt" when the 1990 US Census Migration Residence for Veterans, "State to State Flow", indicate that the Veterans population in Maine and Vermont have been growing at the same rate as the "Sun Belt" States. Maine needs the money it has and much more to adequately provide health care in Maine to Maine Veterans. In a 31 August 1998, letter sent by the PVA National President Kenneth C. Huber asked all paralyzed Veterans to write the President of the United States to ask him to "...preserve and protect the care veterans... receive from the VA. It is important that a new leader be found who recognizes the importance of specialized services who will slow the VA's rush to establish a dollar-driven managed care health system." In this letter PVA members were asked to write opposing the renomination of Dr. Kenneth Kizer, as Under Secretary of Health at the Department of Veterans Affairs. This is a key issue that must be addressed. We need an Under Secretary of Health at the Department of Veterans Affairs who will fight aggressively to see that Veterans receive top quality state of

the art medical care. We desperately need a VISN 1 Director who will be responsive to the needs of the Veterans served in that VISN and who understands the unique travel concerns and nature of people in the VISN. As Governor King of Maine says in a recent letter, "...as a result of Dr. Fitzgerald's comments I became very concerned about the funds that were being transferred from the Northeast to the South and Southwest areas of the United States, along with serious concerns about Maine veterans having to go to Boston in order to receive treatment." Governor King's concern is shared by the Coalition of Northeastern Governors. In an unusual move, a letter signed by all of the Governors, has been delivered this week to Secretary of Veterans Affairs Togo West expressing in the strongest possible terms concern over what is happening to the care of Veterans in New England. VISN 1 and Togus VAMC need back many of the Doctors and other health care professionals lost in the past three years. Medical decisions have to be left in the hands of medical professionals, not administrative personnel who look only at the dollars and cents of a medical question. I want you, our elected representatives, to ensure America's commitment to veterans is honored. Now is not the time for our Nation to turn its back on those who sacrificed that we could all be free. Were it not for the Veterans of this Country this

hearing would not be held this day and you would not be representing the people. I ask you as members of the Congress to now stand and fight for the Veterans of this Country with the same determination we once fought for you. Thank you!

Mr. SHAYS. Mr. Williams, thank you for testifying. Thank you for sharing that story.

Mr. Hite.

Mr. HITE. Mr. Chairman, distinguished members of the subcommittee, I originally planned to say good morning, but good afternoon to you.

The American Legion is grateful for the opportunity to share with the distinguished members of the Subcommittee on Human Resources our perspective on the impact of the Veterans' Equitable Resource Allocation, VERA, methodology and the Veterans' Integrated Service Network Management Structure, on the quality of care and services with particular focus on VISN–1, also referred to as VA New England.

I would like to first reiterate the appreciation of the American Legion for the diligence displayed by this subcommittee with regard to your work, your hard work for those brave men and women who have served this Nation so faithfully in the Persian Gulf, as well as I commend you for today's hearing. The gentleman from New York, I know earlier in New York, it's also part of my territory that I cover. I am very appreciative of the work you all have been doing up there as well.

Before I get started though, as a matter of correction to my written statement, I must apologize to Dr. Garthwaite. We referred to him as the Under Secretary for health. I think Dr. Kizer still occupies that position. I would just like to say we recognize and respect Dr. Garthwaite as the Deputy Under Secretary.

Today, however, we are assembled to address the issue of the relationship between VERA and/or the VISN structure and the numerous concerns of veterans and other stakeholders across New England regarding quality.

Just for a quick matter of background, in January 1997, the American Legion National Adjunct recognized the potential for disruption of services posed by each of these fundamental changes and put together a special task force to investigate exactly the issue before us now. In the time since then, this task force has conducted site visits, town hall meetings, and held meetings with congressional district office staff members, the folks that answer the telephones when veterans call within six individual networks, VISN–1, 3, 4, 5, 18, and 21.

In the interest of brevity and with a sense of fairness to the other panel members, I only want to add a couple more points to my written testimony. First, while the impact of VERA has often been overstated, the model does impact care indirectly by providing incentives to provide less intensive outpatient based care to an increased number of veterans. VERA does not necessarily provide incentives to reduce specialty services because VERA is only intended to fund networks and not individual hospitals.

It is the responsibility of the network director, along with the executive leadership council or team or group, depending on which network you are in, to develop an internal funding method which in conjunction with stakeholder input is sensitive to veterans' needs across the network. Thus, it is the responsibility of network leadership to determine the adequacy of resources. If resources are insufficient to support a delivery system that is truly sensitive to

all patient needs, then it is the responsibility of leadership, again working with stakeholders, to trumpet that message.

In VISN–1, this does not seem to be the case. Issues such as insensitivity in the discharge planning process as determined by an investigation at West Roxbury 2 years ago in the nursing home care and spinal cord injury units, program closures or realignments with little or no stakeholder input, reports of one registered nurse providing coverage for two 60-bed wards housing chronically ill veterans at Bedford, and other stories of staffing shortages, as well as continuous outcries from veterans outside of Boston, particularly in Maine, continue to create concern and heighten anxiety across all stakeholder groups.

The pervasive nature of these concerns, the fact that they are coming from all stakeholder groups, and the fact that they have been essentially unrelenting appear to raise legitimate questions about quality.

It is difficult to quantify the impact on quality because quality is part of a larger equation which includes access, satisfaction, and efficiency, all to create value. But it does seem reasonable that value, as defined by veterans, is diminished when veterans and stakeholders perceive the health care system as being unfriendly because veterans are required to travel extensive distances away from their families for in-patient or specialty care, or when they experience firsthand or hear about all the controversy that exists within VISN–1.

This issue in all fairness, is not isolated to only VISN–1. However, a number of networks face the issue of providing tertiary and specialty services to veterans in rural areas as well. For instance, a good model is being developed currently in VISN–21, which has already enjoyed some success at establishing several contracts for care and in-patient services at various points across northern California, which is also remote. What does appear to be extremely problematic for VISN–1 relative to some other networks in this regard is their degree of difficulty at establishing these contracts for care and closer proximity to veterans' homes when VA cannot produce the service less for locally. By locally, I mean, sir, less than several hours away by car with no snow on the ground.

VISN–1 is trying to develop a hub and spoke delivery model, but it is not entirely clear to veterans what services should be available at each spoke. A prime example is the fact that until just recently, veterans from Maine had to travel to Boston for MRI, an issue which you have already addressed today. I just want to address it a little further by saying that it took almost 3 years to establish reasonable access to this routine service, and based on the questions and answers today, it is my understanding that as many as one-third of folks in Maine needing MRI's are still going to have to go to Boston. So how much hope can there be for veterans who require more specialized services that cannot be provided in Togus.

Another example comes out of Vermont, an area that hasn't really been touched on today in depth, where it was reported to me just recently by our veterans' service officer there that veterans are being referred to Boston for ophthalmology services. It is our understanding ophthalmologist services are considered—let me regroup here. Surely ophthalmology services are considered so spe-

cialized or not considered so specialized that they should be provided only at hub facilities.

In conclusion, the repetitive nature of so many concerns at best seems to suggest an inability to solve the problems in VA New England or at worst, the persistence of these negative perceptions may reflect an insincere commitment toward developing consensus solution. Therefore, the American Legion believes in light of such a persistent and wide array of concerns from multiple perspectives, dramatic changes are warranted.

This concludes my statement, Mr. Chairman. I will be pleased to answer any further questions you or any other Members would have.

[The prepared statement of Mr. Hite follows:]

STATEMENT OF ROBERT HITE,
NATIONAL FIELD REPRESENTATIVE
NATIONAL VETERANS AFFAIRS AND REHABILITATION COMMISSION
THE AMERICAN LEGION
BEFORE THE
COMMITTEE ON GOVERNMENT REFORM AND OVERSIGHT
SUBCOMMITTEE ON HUMAN RESOURCES
UNITED STATES HOUSE OF REPRESENTATIVES
ON
THE IMPACT OF VETERANS EQUITABLE RESOURCE ALLOCATION
AND VETERANS INTEGRATED SERVICE NETWORK STRUCTURE ON
THE QUALITY OF HEALTH CARE SERVICES
IN VETERANS INTEGRATED SERVICE NETWORK # 1

SEPTEMBER 25, 1998

Mr. Chairman and Distinguished Members of the Subcommittee:

The American Legion is grateful for the opportunity to share with the distinguished members of the Subcommittee on Human Resources our perspective on the impact of Veterans Equitable Resource Allocation (VERA) methodology and the Veterans Integrated Service Network (VISN) structure on the quality of care and services with particular focus on VISN 1, also referred to as VA New England Health Care System (VANEHCS), headquartered in Boston. I would like to first reiterate the appreciation of The American Legion for the diligence displayed by this subcommittee with regard to its oversight of VA benefits and health care for those brave men and women who served this nation faithfully in the Persian Gulf.

Today, however, we are assembled to address the issue of quality health care and services being provided to veterans across New England, and to determine the relationship between VERA and/or the VISN structure and the numerous concerns of veterans and other stakeholders in this region. This is an issue that The American Legion has been actively involved with for nearly two years. In January 1997, The American Legion recognized the potential for disruption of services to veterans posed by VERA and VISN and assembled a special Task Force to investigate exactly the issue before us now. In the time since then, the Task Force has conducted site visits, town hall meetings, and held meetings with the congressional district office staff members within six individual networks--VISNs 1, 3, 4, 5, 18, 21.

Over the course of these visits we have learned much concerning VERA and the VISN structure. For instance, there is still a wide degree of variation among networks in some important areas such as how resources are distributed within the network, and how data is captured. However, there are several recurring factors related to the transition of VHA field assets into a system of integrated delivery networks that have emerged as well. The American

Legion believes the simplest format to describe these lessons learned and to discuss the operations within VISN 1 specifically is the following framework:

1. **Adequacy of Resources--VERA impact on "buying power" and the ability to generate additional revenue streams;**
2. **Leadership--stability, clear and consistent vision, and consensus building;**
3. **Visible Performance Improvement in Access, Satisfaction, Quality, Efficiency, and Special Emphasis Programs;**
4. **Stakeholder Buy-In.**

Adequacy of Resources:

Beginning with VERA and adequacy of resources, The American Legion Task Force has found that the funding model is only useful in allocating resources to the network level, thereby shifting the financial risk associated with treating patients to the network level. Network Directors are required to hold at least two percent in reserve. From there, each VISN has the responsibility and the authority to fund patient care activities as local management deems appropriate with very few limitations. Although, whatever model is used within a network, it should be sensitive to the traditional missions and consider the patient-mixes as defined by the predominant Diagnostic Related Groups (DRG) at each facility.

The Task Force has found that VERA's impact as the sole driving force behind many of the changes on-going in VISNs hardest hit has been often overstated because there are many factors which influence change. Specifically, The American Legion has discovered widespread restructuring and reengineering activity in each network visited. In other words, many of the changes occurring in those networks losing funds mirror changes in "gaining" networks. Some of the similarity is indicative of a tidal wave of change that has swept the health care industry as a whole, but it is also a sign that there are many factors impacting how health care and services are delivered. For example, the decision to purchase health care services such as acute inpatient care depend as much on the amount of competition in a market and its effect on price or on the availability of qualified physicians in a specific market.

Finally, The American Legion has reported that VERA rewards efficiency and provides incentives to move towards outpatient, primary care. However, the model also encourages networks to increase the number of veterans. These incentives would not be troublesome if there were new dollars for new veteran patients, especially Non-Service Connected, or indigent veterans who are typically poorer and sicker than other veterans, but VERA is a capitated, *per veteran* model of funding, being applied within a fixed revenue environment where the incentive is in stark contrast to that of VERA. Organizations with *per veteran* reimbursement have a financial incentive to attract more users, especially healthier veterans, because theoretically each new veteran generates revenue. Organizations which operate on a fixed budget have the opposite incentive; these health care organizations tend to avoid outreach because of increased resource requirements.[1]

Thus, the *per veteran* amount available for providing care actually shrinks with each new veteran which in turn reduces the margin which is needed to offset the higher costs associated with chronically ill veterans--*shrinking margin*. Therefore, VERA's impact must be examined in terms of the net change in a VISNs "buying power" from year to year. The result from this change in buying power is enormous tension between creating greater efficiencies and generating more revenue from outside resources while simultaneously reaching out and offering a uniform benefits package through enrollment to more veterans who are potentially among the sickest. This tension--*Doing more with less*--is the same challenge faced by all VISNs as we move into Fiscal Year 1999. The American Legion is concerned about the impact of the *shrinking margin*, because there is a line where a network can become adversely selected--demand for services exceeds the amount available. Put another way, doing more with less becomes doing more with not enough.

The American Legion has proposed the GI Bill of Health as a possible solution to the problems of the shrinking margin and adverse selection. Specifically, the GI Bill of Health would afford VA the opportunity to expand its case mix to include younger veterans and their dependents on a premium basis; thus restoring the margin and supplementing the annual appropriation to care for those veterans currently entitled to health care at no cost. The proposal also calls for the authority to bill Medicare and Medicaid. Presently, VA cannot bill either which has a substantial domino effect on its ability to collect from other third party insurers resulting in often contested and unpaid billings.[2] However, The American Legion believes monies collected from the Medical Care Collections Fund should supplement, and not offset annual VA congressional appropriations. Ultimately, until such time as VA is permitted to develop meaningful new revenue streams, the pressure created by the juxtaposition of VERA and a finite resource base will only intensify.

Returning to the current state of affairs within VA, there is still room to increase efficiency and improve veteran satisfaction while sustaining access to and quality of care and services. Specifically, The American Legion has reported that a Patient Centered Delivery Model which is sensitive to the precise medical needs of the veteran population in a VISN's Primary Service Area (PSA) is the appropriate path to ensuring improvement in every domain.[3] Transitioning to this type of model requires both solid leadership and visible performance improvement, the focus of the remainder of my testimony.

Leadership:

There is widespread acceptance of the critical nature of effective leadership in successfully guiding the transition from a hospital based delivery system to an integrated and patient centered health care network. Managing change, whether it be as intricate as redesigning specific business/clinical processes or as broad as the realignment and restructuring of the entire health care infrastructure requires coordinated planning, decisiveness, an understanding of risk, and the ability to clearly and consistently articulate the organizational vision to both internal and external stakeholders.[4]

The most recent examples of the untoward effects of leadership problems have been most notably documented by VA's Office of the Medical Inspector (OMI) report on the VA Hudson Valley Health Care System.[5] To a much lesser degree, The American Legion Task Force also noted that an unusual amount of instability in the senior management positions contributed significantly to slowing the maturation process towards integration and coordination among facilities in VISN 21.[6] Both of these health care systems are on the mend in large part due to dramatic changes and a renewed sense of vigor among senior and mid-level leadership. Leadership is essential for several other easy to understand reasons:

- Leadership establishes the orgzanizational culture through the exemplification of its values.
- Leadership provides the strategic direction.
- Leadership is responsible for ensuring that adequate linkages exist between processes and outcomes.
- Leadership serves as a conduit to all internal and external stakeholders in order to build consensus as to the need and the nature of change.

There is research that demonstrates the relationship between quality in the health care system and the alignment of goals and incentives among all stakeholders.[7] Furthermore, the decentralization of authority and responsibility--key tenets of the current VHA field structure--along with the multiple and well documented challenges posed by today's volatile health care markets place an even greater premium on competent, visionary, and stable leadership to foster trust and inspire coordination than ever before at the network level.[8]

Vision for Change, the defining document for the "New" VA, recognized the importance of communication and consensus building between the health care system and its stakeholders when it outlined specific objectives to do so within each VISN. In this cornerstone publication, Dr. Kizer clearly indicated his intention that the Management Assistance Council (MAC) should serve as a vehicle which embodies the organizational commitment to keeping all of the various stakeholders such as Veteran Service Organizations and congressional district staff members actively involved in the planning and policy process, especially with regard to changing how health care will be funded within the network. (p. 39)

There are examples of where this type of consensus building has worked to lessen anxiety and can be found in VISN 3 where veterans representatives sit on specific service committees charged with evaluating change and the impact of these changes. In VISN 18, there are a number of Veteran (Consumer) Advisory Groups that are proactively used as part of the Quality Improvement Process. Stability and a clearly and consistently stated vision of leadership seem to contribute significantly to fostering a sense of trust among employees and patients, particularly when it is apparent to all stakeholders that management feels a sense of shared anxiety or a feeling that we are all in this together.

In VISN 1, though, representatives to the MAC have repeatedly expressed frustration at not being respected as part of the planning and policy process.[9] This frustration apparently persists despite an Organizational Chart which illustrates a formal "mechanism for **obtaining** and

sharing information between VISN leadership and various stakeholders."[10] The American Legion representatives continue to report that the MAC Meetings remain little more than presentations to disseminate information concerning decisions that have already been made.

For example, several significant programmatic changes have been decided apparently apart from the veteran service organizations. The Nursing Home Care Unit was closed at White River Junction in August in 1996. This decision caught everyone in the veterans community completely off guard. The VISN 1 response to our request for an update on the MAC process to solicit veteran input was that "this issue has been discussed at several Executive Leadership [Council (ELC)] Meetings and was a topic at the Northern New England Management Assistance Council held at Manchester in June 1996." (D. Fitzgerald, MD, MHA, personal communication, August 30, 1996) It should be noted, however, that the ELC is comprised only of the senior management at each facility, and that during our site visit conducted at that time, The American Legion could find no one that recollected hearing about the impending closure. Moreover, in a letter to then VA Secretary, the Honorable Jesse Brown, the Veterans of Foreign Wars Commander-In-Chief expressed the same sentiment, that VSO input was being excluded from these types of decisions and specifically requested a formal 120 day notification period for comments.

Additionally, at a meeting with congressional district office staff members which included a large number of the veteran case workers or constituent services managers, there was almost universal agreement that the VISN did not communicate well with them. In fact, several staffers asked The American Legion for copies of the VANEHCS Strategic Plan. Shortly after our visit, the VISN announced a full-time position to coordinate external communication.

Visible Performance Improvement:

If a VISN is doing all that it is supposed to be doing to provide appropriate patient care, then there should be notable performance improvement in each of what Dr. Kizer defines in *Prescription for Change* as Domains of Value--Access, Satisfaction, Quality, and Efficiency. VISN 1 has demonstrated relatively good performance in those areas defined by the Network Director's Performance Measures. **The American Legion has on numerous occasions been supportive of VA's efforts to introduce accountability to the VISNs through the creation of these measures; although, we have also noted that these measures are not fully sufficient to determine the degree to which a VISN is meeting the total health care needs of the veteran population within its PSA.**

To this end, The American Legion is developing a standardized instrument (the VALUE Workbook and Scorecard) which is both qualitative and quantitative in nature to assess the value of VA health care to veterans. VHA itself is also actively working to identify more accurate measures of performance, particularly in the area of health care outcomes. There are a number of specially chartered clinical groups also working on better program measures, such as the Long Term Care Advisory Board and the Seriously Mentally Ill Committee.

Over the past three years, since the establishment of VISN 1, The American Legion has continuously maintained a watchful eye on operations in New England. For instance, our reports

on VA Medical Centers at Manchester and White River Junction included questions and raised issues about how veteran input was gathered as decisions were made to close the inpatient surgical unit and the nursing home care unit, respectively. VISN leadership responded in a letter stressing the point that the network would become "a comprehensive, integrated, medical care system that will provide (1) improved health outcomes, (2) **improved convenience of care**, and (3) improved cost efficiency."

In the same timeframe, The American Legion recommended in its report on the Togus VA Medical Center that significant weight be assigned to the harsh weather conditions and the relative isolation of many veteran Mainers, especially those in places like Aroostook County.[11] This recommendation was made in the context of changes being made in the Fee-Basis program, mental health fee-basis to be specific, and the VISN response was that these decisions would be made on an individual basis. Since that time, this issue has metamorphosized from just being an issue of Mainers having to travel from the northern reaches of the state to veterans from all parts of northern New England having to travel to Boston for many types of care which is available in the areas closest to their actual home. The American Legion Task Force visit came less than one year removed from these reports and found that with regard to improvement not only were the negative perceptions of care subsiding, they actually seemed to be growing more widespread. For example:[12]

- The overall concern expressed by all stakeholders was for quality patient care. Veterans service organization representatives expressed very little trust in Dr. Fitzgerald and characterized the VA as "unfriendly" in direct contrast to the stated objective contained in the VANEHCS Strategic Plan to create a "Friendly" VA.
- Congressional district office staff members revealed that they were receiving numerous calls from veterans regarding rural access (i. e. Boston is the only referral facility for tertiary care for veterans in the northern tier of the VISN) and complaints about inpatients having to wait too long for nursing assistance. They also conveyed that there was a great deal of anxiety regarding possible cuts in services, as well as a considerable and growing amount of dissatisfaction coming from family members because of issues such as "insensitive" discharge planning at Brockton/West Roxbury to not being able to visit loved ones hospitalized so far away.

  Several of the staff members also voiced personal concerns about the reduction in nursing and its impact on care, stating that they feel there is a real gap between what management and employees were saying.
- VISN 1 Employees and Union Officials related specific concerns about the lack of cross-training for nursing staff which is now being "pooled" for coverage in different areas of the hospital as needed. They also pointed to shortages of qualified nursing staff on the inpatient wards on off-tour hours. One example provided to the Task Force was only 1 Registered Nurse covering two 60 bed wards housing chronically ill veterans.

Earlier this year, The American Legion again returned to New England; this time as part of a larger project to garner insights to veterans' expectations and their understanding of the overall health care system. We held focus groups in Cumberland, Rhode Island and Gardiner, Maine. We had not intended to report these results separately due to the limitations on the power to extrapolate findings from these data to the general veteran population.

However, the volume of calls and letters from veterans in New England has not subsided. The concerns from veterans in Maine have been so persistent that they finally culminated in a request from The American Legion Department of Maine Service Officer to the Under Secretary for Health, Dr. Garthwaite, at our Annual Mid-Winter Conference to examine the unfair and unreasonable referral patterns for care. Therefore, we prepared our findings in the form of a report, included as Appendix A to this testimony. The findings speak for themselves, so I will not expand on them here, except to say that they do seem to support what the stakeholders have been saying.

Stakeholder Support:

Stakeholders are a similar group to Shareholders except that they are emotionally and physically invested in the health care system as opposed to financially. VA stakeholders are veterans, family members, VSOs, employees, congressional delegations, medical school affiliates, and other local community groups whom all have an interest in the well-being of the VA. The concerns, opinions, and needs of these groups are integral components for shaping the direction in which VA should be moving. As networks develop and revise strategic plans, stakeholders must be involved in the process since operationalizing the strategic plan will be delegated down to these channels. The MAC process, as noted earlier, is a vital resource for making changes work and garnering stakeholder support. Without the buy-in of these internal and external lead agents, cooperation and communication will break down and quality of patient care will ultimately suffer.

Conclusion:

In conclusion, VERA impacts how care is delivered by providing incentives to develop cost efficient care models which put the needs of the patient first, and by encouraging networks to treat and provide services to more veterans. The impact of VERA can not be fully appreciated without examining the effects of applying a capitated reimbursement methodology within a fixed-resource organization. Additionally, there a myriad of other factors which influence the delivery of care. To this problem, The American Legion suggests a long term solution in the form of the GI Bill of Health; and in the short term, additional federal appropriations are needed to meet the demands of medical inflation, technological advances, and to cover the expenses associated with complying with the "Patient Bill of Rights and Responsibilities." The American Legion believes a good first step would be to end the current practice of offsetting VA annual congressional appropriations with monies from the Medical Care Collections Fund, and instead use these funds to supplement annual VA congressional appropriations.

Still, there are many improvements which we feel must be made in VA New England Health Care System within existing resources. For instance, the issue of rural access must be

addressed. At present, VISN 1 does not seem to have more "Convenient access to care," as promised. Moreover, it does not seem that patient need has been given the appropriate consideration in determining whether to refer veterans to Boston or purchase care locally.

Finally, The American Legion has raised many of the issues heard here today as well as many others over the past few years, and I am sure that the other panel members will highlight even other issues. The repetitive nature of these concerns seems to suggest at best an inability to identify solutions to these problems, or at worst the persistence of so many negative perceptions may reflect an insincere commitment to solving these problems. In light of the evidence, The American Legion believes dramatic changes are warranted. This concludes my statement Mr. Chairman. I would be pleased to answer any questions you may have.

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[1] Coffey, Richard, K. Fenner, and S. Stogis. *"A Guide to Assessing Organizational Readiness and Strategic Partners, Virtually Integrated Health Systems,"* Jossey-Bass, Inc., San Francisco, CA, 1997, p. 9-26.

[2] Coopers and Lybrand, LLP. *VA MCCR National Study, Cost Assessment and Best Practices,"* April 21, 1998, p. 3.

[3] The American Legion VISN Management and Resource Allocation Task Force. *"Report on Veterans Integrated Service Network # 3,"* September 1998, p. 20-21.

[4] Boland, Peter. Ph. D. "The Role of Engineering in Health Care Delivery," Ch. 1 in *Guide to Managed Care Strategies 1998: An annual report on the latest practices and policies in the new managed care environment,* J. Burns and M. Sipkoff, (eds.), Faulkner and Gray, New York, NY, 1997.

[5] Office of the Medical Inspector. *"Final Report: FDR Hospital, Montrose NY, VA Medical Center, Castle Point, NY, Hudson Valley Health Care System, Veterans Integrated Services Network 3, Summary Report, Section 6,"* December 29, 1997, p. 13, 26-28.

[6] The American Legion VISN Management and Resource Allocation Task Force. *"VA Sierra-Pacific Network, Veterans Integrated Service Network # 21,"* April 13-24, 1998.

[7] Coffey, Richard, K. Fenner, and S. Stogis. *"A Guide to Assessing Organizational Readiness and Strategic Partners, Virtually Integrated Health Systems,"* Jossey-Bass, Inc., San Francisco, CA, 1997, p. 26.

[8] Boland, Peter. Ph. D. "The Role of Engineering in Health Care Delivery," Ch. 1 in *Guide to Managed Care Strategies 1998: An annual report on the latest practices and policies in the new managed care environment,* J. Burns and M. Sipkoff, (eds.), Faulkner and Gray, New York, NY, 1997.

[9] VA New England Health Care Network. *"Draft Strategic Plan: FY 1998-2003, Journey of Change in New England,"* October 6, 1997, p. 58-60.

[10] ibid., p. A-8.

[11] Hite, Robert R. *"The American Legion Site Visit Report of Department of Veterans Affairs Medical Center Togus, Maine,"* April 22-24, 1996.

[12] The American Legion VISN Management and Resource Allocation Task Force. *"Interim Report, (Veterans Integrated Service Network # 1)"* March 2, 1997.

Attachment

THE AMERICAN LEGION

Report of Findings from Focus Groups in

Cumberland, Rhode Island
&
Gardiner, Maine

March 16-17, 1998

OVERVIEW

The transition from a centralized, "hospital-centric" system in favor of integrated networks is building a health care structure that is increasingly welded together by common treatment processes and expanded use of contracted providers rather than "bricks and mortar." The American Legion, in order to maintian its effectiveness at tracking and trending performance in the Veterans Health Administration, believes that an framework built upon the issues associated with health care delivery is better suited to measuring the impact of change on veterans.

To this end, The American Legion is gathering information from veterans as part of a project to standardize our oversight activities through a methodological approach to data collection and analysis which features just such an issue framework. The qualitative information we are collecting during this phase of development is essential to furthering our organizational understanding of the factors that affect veterans' perceptions of their health care system. This information will also then be used in the next step which is the creation and dissemination of a quantitative survey.

Thus far, The American Legion has conducted two in a series of focus groups comprised of VA system users in Gardiner, Maine and Cumberland, Rhode Island. The findings and potential questions for further investigation will be incorporated into a larger report once all the groups have been completed. However, this report is being submitted because of concerns raised at The American Legion's 75th Mid-Winter Conference immediatelt following an address from the Deputy Under Secretary for Health.

Objectives of the Focus Groups

1. Determine how veterans who use VHA services, define and rate VHA in terms of:

   -Access to Care
   -Quality of Care
   -Overall Satisfaction

2. Determine the informational needs of veterans:

   -What types of information do veterans need?
   -How can we facilitate the process by which they are informed?

METHODS

Focus Groups will serve as the primary research vehicle during this phase of our project, because they are conducive to unveiling the often profound reasons that shape attitudes and opinions on specific topics. Focus groups are also widely used by market research firms in the development of questionnaires for use in more widespread, quantitative surveys that are generalizable.

A topic guide, which includes 11 open-ended questions, was used to prompt discussion. Participants were encouraged to speak freely following only the rules of polite conversation. The moderator also briefed the group that there were no right or wrong answers to lessen any anxieties that might be present from participating in group discussion. The topic guide for the focus groups is included in Appendix A.

Veterans were recruited from a list provided by The American Legion Service Officers in both Providence and Togus. To be eligible to participate, each veteran was required to have received services from VA within the two past years. There were 5 veterans who met the recruitment criteria in attendance at the discussion in Cumberland and 11 in Gardiner. The breakout characteristics of the participants in these groups is presented in Appendix B.

The group discussions lasted approximately one and a half hours and were conducted in the American Legion Posts in Cumberland, Rhode Island and Gardiner, Maine. Participants were provided with copies of the Topic Guide prior to the meeting to facilitate a more meaningful discussion. Since it is not the intent of our research at this point to determine issue saliency, this prior receipt of the topic guide should not be regarded as an influencing action.

Finally, the limitations of this type of research are that results cannot be generalized to the population as a whole, and/or the findings may be skewed for a number of reasons with a group this small (e. g. all the participants were Legionnaires, there may be something statistically significant about those 16 veterans who elected to participate at that particular time of day in the middle of the week).

FINDINGS

The findings from these focus groups will be incorporated into a larger project aimed at developing a standardized methodology for assessing VHA performance based on what veterans want and expect from their health care system. Specifically, the research we are currently doing starts with a qualitative phase, as reported here, and transitions to a quantitative phase (To be developed). Once we have compiled enough

data, the results will be used to determine the informational needs of veterans to be served through an annual "report card."

The purpose of reporting these specific findings at this time stems from issues regarding the availability of services at Community Based Outpatient Clinics in Northern Maine and to what appear to be unreasonable patient referrals. These issues were raised both during our debreifing with local Legion officials and were raised at The American Legion's 75th Mid-Winter Conference to the Deputy Under Secretary for Health who responded that he would examine these activities in Veterans Integrated Service Network (VISN) # 1.

"Access to Care"

Access to Care has previously been identified as an important issue for veterans. The veterans who participated in these focus groups, though, were asked to define what that means to them. Based on the responses from these veterans, there appears to be a simple, but precise understanding of the concept of Access--**For any veteran, appropriate care should be available when you need it, within a reasonable distance and with a reasonable wait time**. However, upon probing a little deeper, several dimensions to the construct emerged which may explain the factors that shape their own views on access to care in the VA.

There was a pervasive sense of anxiety among these groups of veterans with regard to Access. Even for those veterans who rated VA as being more accessible than it has been in the past, there seems to be the feeling that the future availability of care may be in jeopardy. Much of this anxiety seems to be attributable to several factors:

- **A growing shortage of staff**

  --"Keep it open and we need more nurses plus doctors." (veteran, Gardiner)

  --"We need to keep Togus a full service hospital." (veteran, Gardiner)

- **VA's emphasis on Means Test and third party insurance seems to be sending the message to veterans that there access to care could be threatened**

  --"The VA needs to provide full and complete services. I am a 100 % disabled and can not get any outside health insurance and must depend on VA for all my medical and health care." (veteran, Gardiner)

  --"Stop having to do my and my husband's Means Test every couple of months--between Togus and Atlanta--it has been eight times for this year already...My husband and I are very close to the limit on the Means Test and Social Security

gets a raise every year and I am petrified that we will be dropped." (veteran, Gardiner)

--"You guys in the [American] Legion should tell veterans not to drop their [Medicare] Part B; they could really be hurting if they drop their Part B." (veteran, Cumberland)

--"Access to care means the ability to get proper medical care regardless as to the ability to pay...I do not feel that outpatient care is available for me because I was told it will cost me $45 per visit. That's why I say, 'No!'" (veteran, Cumberland)

- **Increased travel to Boston for services were cited often by respondents in Maine as a major source of concern. The conversation regarding this issue grew very emphatic and at times emotional. One possible reason for this emotion may be resentment that their medical center seems to be growing smaller, while Boston--in their eyes--remains unaffected. This perception is exacerbated by the fact that reportedly there is at least one tertiary facility in Portland which could provide many of the services for which veterans are being referred to Boston.**

--"Stop the trips to Boston and keep it here in Togus."

--"Keep Togus because they provide much better care [than Boston]."

--"Vets are going to Boston for some treatments that could be done in Maine. This is very hard on older vets!"

--"I had to travel to Boston for an MRI: this makes no sense to me. Vets should not have to travel long distances for MRIs when there are so many readily available in Maine. I even know of a MRI that travels around in a van!"

- **Respondents in Maine perceived excessive waiting times as a threat to access because many feel that the only reason they must wait is because of too few staff. These attitudes apparently persist despite several new outpatient clinics across VISN 1 and particularly in Northern Maine. On the other hand, participants who used the Providence VA reported that timeliness is not an issue at their hospital based on their experiences. This could be because of more specialists at Providence and a much shorter commute to Boston for tertiary care.**

--"Access to care has improved, but needs improvement on wait time." (veteran, Gardiner)

--"We need more doctors, thus freeing up those we have to have more time with their patients." (veterans, Gardiner)

--"There are pharmacy delays and you have to wait too long for services in prosthetics, though they are knowledgeable in the work they do." (veteran, Gardiner)

--"The doctors did a great job, I got good treatment, my appointment was timely." (veteran, Cumberland)

--"As a matter of fact, they even called to remind me of my appointment." (veteran, Cumberland)

Quality

The majority of participants were able to offer opinions on how well VA was at providing quality, though most could not accurately define the construct. This makes sense given the multidimensionality of quality; however, almost all respondents were able to answer the question about whether they were better off having received treatment from VA. For those respondents who did define Quality, they did so in several ways which could reflect that veterans link quality to the structures in place and the degree of helpfulness they perceive from the staff.

- **Veterans in the groups who could not define Quality, but who had opinions on the quality of VA health care tended to focus on the level of personal service and attention they received and whether it was perceived as friendly and genuinely concerned.**

  --"Togus is great; Boston is Hell." (veteran, Gardiner)

  --"Excellent! The people go out of their way to help you. I believe the nurses have too many patients at a time to care for." (veteran, Gardiner)

  --"It depends on how you are asking about quality. Some [services] yes; some [services] no." (veteran, Cumberland)

- **Veterans who did define quality, and had opinions were able to include at least one dimension of quality (structure, process, or outcome) into their perception.**

  --"The treatment is first class, but there is a lack of professional staff. We need another heart doctor." (veteran, Gardiner)

--"Quality to me is having trained professionals there to take care of you." (veteran, Gardiner)

--"I think they give quality when they care, when they show that they really care about you." (veteran, Cumberland)

--"The quality is great. I am better off now [that I am receiving care from VA]. The staff is great, but they could use more." (veteran, Gardiner)

Overall, the comments on quality of care were positive. In fact, among the two groups of participants, there was a common theme that once you were inside the doctor's office, you were generally treated well. **The primary issue, which for these veterans, seemed to impact perceptions of quality most was access--or the persistent difficulty respondents still experience trying to gain access to the type of care they feel they need, and it is this issue that appears to be having the greatest impact on shaping the perceptions of these users of VA health care.**

In future Focus Groups we will try to explore deeper the reasons behind why Quality seems to be such elusive concept for veterans and look for possible ways to bridge this gap whether it be through increased efforts to educate these veterans or by making changes that are more in synch with the needs and desires of most veterans once this is determined. **For now, what is most significant, based on these discussions is that veterans appear to view quality differently than providers and administrators, and it may be this perspective that is essential to creating a patient-focused delivery system that is, indeed, patient-focused.**

Satisfaction

The veterans who participated in the discussion groups reported being generally satisfied based on their own experiences. In fact, the only major source of consternation for the respondents centered around the referrals to Boston. While this is recorded here under access, it is clear from the context of the discussions that while veterans in Maine were very satisfied with the way they are treated at Togus, they were adamant about having to go to Boston for their care. The other major source of dissatisfaction of veterans concerns the issue of the means test and co-payments.

--"It's a Double Standard; they don't ask any questions about income when they [the military] swear you in, so pay shouldn't be an issue for care in VA." (veteran in Cumberland, RI)

In general, the veterans who participated in the discussions overwhelmingly had kind words to say regarding their care. However, these comments seem to reflect more of

an appreciation for the men and women who provide care. In other words, they seem to be satisfied with the people who they see on a regular basis, but lack the necessary trust in the system to be truly satisfied with the network.

Debriefing Local Legion Officials

After each of the focus groups, we discussed the overall themes of the conversations. The debriefing sessions were intended to alert local representatives to some of the concerns raised and to provide them with an opportunity to comment on any other concerns that may not have been experienced or discussed by the participants in our groups. **Upon hearing some of the responses to the topic questions, several local officials offered the opinion that at least part of the problem may come from the fact that VISN management is seen as untrustworthy to many veterans. Furthermore, these officials hypothesized that much of the anxiety we perceived may be a product of so many changes taking place without any apparent consideration of what is important to veterans.**

The following issue was raised during our debriefing and at the 75th The American Legion Annual Mid-Winter Conference and the Deputy Under Secretary for Health indicated that he would look into the matter. It was reported that outpatient clinics in Maine were not accepting veterans who presented with acute illnesses such as flu. We do not have any evidence at this time to support this claim; however, our Service Officer in Togus will be monitoring the reports and tracking them. Because this issue was also echoed by a Veteran Service Agent in western Massachusetts, and Legion representatives in both Massachusetts and Connecticut, **there seems to be a need to clarify the policy of these outpatient clinics with regard to the services they offer.**

It is the belief of The American Legion that these outpatient clinics should be able to offer a basic primary care package which would include the ability to handle walk-in patients who are truly sick and in need of medical attention without having to drive the three to four hours (one-way) to Togus for urgent care. Specifically, The American Legion understands that these clinics are not intended to serve as buildings to house "Sick-Call," but it seems that it would be more cost effective and customer friendly/focused to use these clinics as though they were group or individual primary care practices. A practice model would allow for the treatment of veterans who are sick, just as you or I would access care. Anything other than a primary care model seems to encourage more costly use of Urgent Care Clinics or discourages use altogether until such a time as the veterans' condition worsens to the point of requiring an inpatient stay.

It was also reported in Providence that those veterans contacted during the Operation Stand-Down were not being provide follow-up care. Again, because this issue of conducting outreach to generate new unique veteran workload and then not following them through Primary Care Clinics was reported in Easthampton as well there seems to be a need to clarify this policy too.

Conclusions

The third dimension to access seems to concern **referrals** for care and the distances associated with these referrals. While we were unable to get members of the groups to clearly define "reasonable distance," we can assume with some certainty that veterans do not like having to travel to Boston or traveling from Northern Maine to Togus. On the other hand, the issue was not even brought up in the discussion in Cumberland which is situated 50 miles south of Boston on the Rhode Island border.

From these responses, it seems that the veterans in Maine who participated in the group feel a sense of community with their hospital in Togus. Furthermore, because of their stated preference to go to Portland for those services most often provided in Boston, they share a sense of wanting to stay within the boundaries of their own state. In the case of Maine, this may not be such an unreasonable position given the severe weather conditions and extreme distances which veterans must negotiate just to reach Togus. **There appears to be an absence of any guidelines regarding what services will be provided at the outpatient clinics and to whom services will be offered.**

Finally, based on these findings, it seems that these veterans relate to their local facilities which is consistent with the idea that health care is local. Other significant findings which warrant further examination in the quantitative phase of this project are the relationships among veterans' perceptions of the three concepts discussed. The statements made by each of the veterans participating also indicate that they are very interested in their health care system and eager to learn when they believe that they are being told the truth.

FOCUS GROUP (FG) GUIDE:

VHA System Users

Purpose Statement

The American Legion is currently developing a "Report Card" on VA Healthcare. In order to make the information contained on this Report Card more useful for veterans we would like you to briefly answer the following questions. The questions should not take any longer than 15-20 minutes, but we do ask that your answers be as thoughtful as possible to help us develop as accurate a Report Card as possible for all veterans who use or who want to use VHA.

Please bring the completed FG Guide to the group discussion we have set up in your area. We will be collecting them at that time. Also, the dsicussion will provide you the opportunity to discuss in greater detail any points you may wish to make.

The American Legion is interested how you feel about the manner in which you are treated and if you believe that your treatment has been beneficial. Therefore, we have invited you to this discussion in order that we may record the opinions and feelings of veterans who are currently using VA services. Finally, on behalf of The American Legion, we appreciate your cooperation.

Instructions for Participants

- The discussion will be audiotaped to increase our accuracy in understanding your opinions. If you have not signed a Consent Form, please do so now.
- Please speak clearly and so that the recorder will pick up what you are saying.
- We want to hear from everyone in the group, so we ask that you be courteous to the other participants and permit them to share their opinions;
- Finally, this is not a test; there are no right or wrong answers, but please explain your reasoning for your opinions as much as possible.

Instructions to moderator-- Your role is to facilitate a discussion among the participants. **In other words, empower the participants--you are there to learn from them. Particpants must sign a release prior to turning on the audiotaping equipment. Additionally, you need to read the Consent Statement to them. Once the discussion is underway, it is your function primarily to guide the discussion by introducing topics and providing transition should the conversation get bogged down. The following schedule of topics is a guide; the topics may be discussed in a different order or not at all. You should probe for deeper reasons for perceptions only if they are too vague or do not seem to fit into the context of the discussion. Finally, the discussion is not therapuetic; rather it is only intended to gain insight to veterans' opinions, feelings, and perceptions regarding VA's ability to meet their clinical needs. Remember that participation is voluntary, so please thank the participants at the beginning and end of the discussion.

Group Settings

Group Size: 7-12
Timeframe: 1 to 1 1/2 Hours
Location: TBD
Seating Arrangement: Participants should be seated in a circular fashion, preferably without any barriers (i. e. a table) between. You should take a seat along side the participants; the goal is for you to have the same vantage point as any one else in the circle. Also, you should be able to acheive eye contact with anyone who is speaking.

Consent to AudioTaping

I, _____, authorize The American Legion through its representatives to audiotape my comments made during this Focus Group on _____ (date/time). I understand that my participation is strictly voluntary and that no offers or promises have been made in exchange for my participation; and likewise I have made no such promises or offers. I further understand that the recording is for accuracy purposes and will be used for no other purpose than specifying veterans' perceptions of the status of VA Health Care and how well VA is meeting veterans' needs. Finally, I understand my comments will be reported anonymously as part of a series of similar Focus Groups.

_____
Signature

_____
Date

Discussion Topic Guideline

1. What does "Access to Care" mean to you?

2. Based on your definition of Access to Care, do you feel that VA is accessible?

3. Please define what the following terms mean to you and rate the VA at meeting this standard: (P = poor; F = fair; A = Average [neither good, nor bad]; G = Good; E = excellent)

	P	F	A	G	E
Courtesy--	1	2	3	4	5
Quality--	1	2	3	4	5
Emotional Support--	1	2	3	4	5
Family Involvement--	1	2	3	4	5
Satisfaction--	1	2	3	4	5

4. What one thing (most important to you) could VA do better to satisfy your needs?

5. How many times have you been admitted as an inpatient in the past two years? How many outpatient visits have you had in the same time?

6. Have you had any other options for you treatment offered to you?

7. What types of support would you like to see made available to your spouse or other family members?

8. Do you feel that you are better off now than before you began receiving care from VA? Please explain, briefly.

9. If you were an inpatient within past two years: Do you feel as tough there were enough staff to meet your medical needs on the wards? If not, please explain.

10. For outpatients: Do you feel as though you are provided frequent enough follow-up appointments for your medical needs? If not, please explain.

11. Are there any other concerns which are not covered in this questionnaire which you feel are important? Please explain why you feel they are important.

APPENDIX B

Participant Profile--Breakout Characteristics

VA Services used within past 2 years:

acute inpatient 6
longer term inpatient (inpatient stay of more than 30 days) 1
outpatient following inpatient 11
pharmacy 13

Service Connected:

Yes-7 Percentage--100% 5
No-9 70% 1
10% 1

Sex:

Male 10
Female 1

Age: Range between 55 and 78.

55-1; 62-2; 63-1; 65-3; 66-4; 67-1; 68-1; 70-1; 72-1

Theater of Combat:

WWII-2
Korea-11
Vietnam-1
Persian Gulf-0

Educational Level:

HS--5
HS/GED--5
Some College--4
College Grad--1
No Response--1

Do you have anyone at home who could take care of you if you were to become seriously ill? Yes--6 No--10

Mr. SHAYS. Thank you very much.

Dr. Schwartz, you will end up the dialog. I'm told we'll have votes in 10 or 15 minutes. So we are going to try to make sure we just get the key points from this panel and not keep you to have to wait after.

I will just say for the record, you paint a very distressing picture, but a very important one for us to hear. I am particularly grateful that the members of the previous panel have stayed to listen to you. That is the right thing to do and it's appreciated very much. So not only are we hearing this, but they are hearing it as well. I thank you.

Yes, Dr. Schwartz.

Ms. SCHWARTZ. Good afternoon, Mr. Chairman. Thank you for your interest in veterans and for holding these hearings today. I would like to introduce myself as being medically retired from the U.S. Air Force Nurse Corps. I am a disabled veteran. I also have had the opportunity to receive a doctorate from the Yale School of Medicine in health policy and administration.

I temper my remarks today coming from the view that you have just stated, to ask for a response to some of the things that I have heard today. So I will refer you to my written remarks for some of the more detailed aspects of my concerns.

One of the things that I wanted to say right out is the fact that the Veterans' Equitable Resource Allocation System, which is based on the premises that we are going to see a migration of veterans from the northeast to the sunbelt States is not born out by the statistics that have been published by the VA. I can tell you that several things went into this finding. First, there was a massive revision of the VA healthcare system at the same time there were great changes in the eligibility criteria for care. This created a situation where it was no longer the number of veterans that lived some place that was the marker, the marker was the number of eligible veterans there. What happened was that—it is no longer the veterans in the area, it is those that are eligible.

According to 1995, 1996, and 1997 published figures, there has been no mass migration or appreciable decline in the number of eligible veterans served in VISN–1. In fact, the number of eligible veterans has increased by 4,483 since 1995. This increase can be attributed to several factors. One of them, which is subscribed to by many, is the fact that this migration did not materialize because the poorer, older, chronically ill veterans that make up the mainstay of VISN–1 users do not have the physical or financial wherewithal to move to the southern climates. Characteristics published by VA of VISN–1 veterans indicate that veterans there are older, have more service-connected disabilities, and more veterans are rated 100 percent service-connected disabled than the national average.

One of the things that this suggests is that there is a major flaw in the model designed to equalize the resource apportionment for care of veterans. A data driven system should have guided these funding decisions before, before they were implemented, and the data was there. For example, the VA healthcare has a luxury that no other healthcare system in the United States has. They know exactly where their patients live, and they know exactly what is

wrong with them because they receive a monthly compensation check and the VA knows exactly why they are compensating them. They have the luxury of knowing where they are, and what is wrong with them. These should be the things that guide their planning.

This information should have been what guided the planning. One of the concerns is that there is also a vast difference in the present capitation model categories between the basic and the special care. As Mr. Allen brought up earlier, it is hard to fit people into one of the other categories. Clinging to these numbers as a way of paying for care is both unrealistic, imprecise, and fails to reflect any variation in acuity of care of veterans' needs. Since it began, the VA has never known exactly how much it costs to care for a veteran. We will only know if this system is cost effective when we take the price tag off the veteran and put it on the cost of the service, the cost of labor, the cost of care.

I ask you to consider something that we have encountered in Connecticut, and I am a veteran of the consolidation of the VA Connecticut. Although there is much to be proud of in this consolidation and the sacrifices and creativity that has become the expected contribution to VISN–1 by VA Connecticut, there are some things that may stand and deserve our notice. First, of the nine hospitals in the VISN, VA Connecticut alone accounts for 28 percent of the increased number of veterans being served since 1995. Recovery of third party payments by VA Connecticut has been the best in the VISN and in keeping with the spirit and the goals of the new VA. Veterans bringing in these funds and choosing VA Connecticut as their providers have a right to expect that those dollars will be available to fund the proper care they need efficiently and expeditiously.

However, it has been reported that MCCF dollars recovered by VA Connecticut were diverted to the VISN to offset losses by other hospitals in the area. Only when Connecticut's congressional delegation, mainly Congresswoman DeLauro, argued that the law required that these funds stay with the facility to provide the care, was the money returned. Interestingly and more disappointingly, VA Connecticut's budget was then taxed, reduced if you will, by the amount of the MCCF funds. I ask you, sir, where is the incentive?

I want to bring to your attention that one of the best programs that VA Connecticut has is the fact that long before it was in vogue, we reduced the number of inpatient psychiatric beds under Mr. Ng from 178 to 32. They transferred 60 percent of the resources to community-based support programs. At that time the average length of stay of a veteran in that program in the hospital per year was over 200 days. With this shift, with this downsizing and the shift of the resources, those same veterans have an average stay of approximately 17 days a year. This is the way the system was meant to work.

However, I am sad to tell you, sir, that this very program is on the chopping block. It is up for grabs. It has been cut and it will continue to be cut, something that really is very efficient and effective. Why is that? It is because of the failure of the VISN to make much-needed steps for cost cutting in hospitals that have lengths of stay of 60 days a year.

Mr. SHAYS. You said 16 or 60?

Ms. SCHWARTZ. Sixty, 6–0. Compared with VA Connecticut's 12 days a year. It is a failure to reduce costs in some VISN hospitals with low census of 9,000 compared to VA Connecticut's 31,000. It is a failure to cut the per capita expense of veterans from $7,500 compared to VA Connecticut's $4,491.

I ask you, where is the incentive? There is no reason to reduce VA Connecticut by 1 penny until we know what VISN–1 will look like operationally and financially, when there is some effort made to address the consolidation that clearly needs to happen elsewhere in the VISN. There is no reason to compromise VA Connecticut's capacity to care for VA eligible veterans until that time.

Mr. Chairman, in my advocacy for veterans, I have traveled throughout VISN–1. I was the regional director for Vietnam Veterans of America for 6 years. I have also traveled to many parts of our Nation, and this I can tell you. VA is not product lines or funding streams. VA is not VERA or VISN's or data-driven decisions. VA is people, veterans. For those of you who do not know us, who only see us as numbers, let me say this. Health care in the VA is not free care for veterans. We paid a mighty high price for this admission, an eye, a leg, a piece of brain, a future, a family, our hopes and dreams. No, Mr. Chairman, it is not free. But veterans willingly paid that price to serve this Nation. Thank you.

[The prepared statement of Ms. Schwartz follows:]

Mr. Chairman I would like to thank you for your continued interest and support for America's veterans and for addressing the very vital topics of today's Hearing. I am honored to have the opportunity to share with you and the Committee some of my concerns and observations about the dramatic changes that are taking place in the Department of Veterans Affairs Health Care System.

I would first like to preface my remarks by saying that my perspective on these changes are informed by my own experiences as a Disabled Veteran and my Doctoral studies at the Yale School of Medicine, Department of Epidemiology and Public Health. I approach today's topics from a pragmatic view that cost effectiveness in delivery of health care is important but should never be at the expense of the quality, efficacy and compassionate care of America's veterans in need.

In FY 1993, before the institution of the VISN system, the majority of veterans seen in VA health care facilities were not treated for Service Connected Disabilities (SCD). (National Center for Veteran Analysis and Statistics,1993) During the summer of 1992, there were four suicides by veterans under the care of the West Haven VAMC. The veteran community and the public of Connecticut will long remember the aftermath of those suicides. Because of these tragedies, it was soon learned how under funded the West Haven VA Medical Center Psychiatric Service had become. The entire Congressional Delegation had to prevail on VA Central Office and Secretary Derwinski to restore funds which had originally been earmarked for West Haven but had been siphoned off by the Regional Office in Buffalo for other projects.

According to scales of VA health care expenditures for that year, Connecticut was 29th in the nation in the number of veterans and 43rd in the amount of VA federal health care dollars the state received which amounted to $ 1,015 per veteran. When one considers that the Veterans Equitable Resource Allocation (VERA) system was designed to assure a more equitable distribution of VA health care dollars, these findings suggest that CT. was in fact in a one down position before this program was implemented.

Veterans Equitable Resource Allocation

The basic premise of this system hinges on the notion that there has been a migration of veterans from the New England and some Midwestern States to the "Sunbelt". When the VERA was first planned and implemented, VA actually stated that the ideal database of current eligible veterans (users and non users) by network did not exist.(Kizer, 1996) Although this is technically correct, VA does have the luxury of knowing where a vast majority of the now Priority 1 (Category A) eligible veterans reside by state and city. Because changes in priority for treatment now correspond to percent of disability and/or payment of a pension, these veterans

also receive a monthly check from the VA. VA also has documentation of the distinct nature of the illness, injury or disability for which the compensation is provided which could guide planning of health services programs at the local and national levels.

Undertaking a massive revision of the VA delivery system at the same time there has been a substantive change in the eligibility criteria for health care has created a situation in which the marker for determining funding priorities is no longer the population of veterans between or within VISNs. Rather the target is and must remain VA eligible veterans. According to VA's 1995 - 1997 published figures, there has been no migration or appreciable decrease in the numbers of veterans served in VISN 1. There are only 7 VISNs that have reported a decrease in number of eligible veterans. Curiously, in FY 1997 VISN 18 which includes the "Sunbelt States" of Arizona, New Mexico and a portion of Texas was one of the VISN's to report a decrease in the number of veterans served.

These dynamics suggest that there is a major flaw in the model designed to equalize resource apportionment for the care of America's veterans. VISN 1 ranks 7th in the number of VA eligible veterans and reports that it currently serves 42.33% of those veterans residing in the service area. (Kizer,1998) Per capita cost per veterans has decreased by $ 353 since 1995.

The major premise of a migration to the "Sun Belt is not borne out in the numbers of VISN 1 veterans who are using VA. The American Legion has reported that the shift in VERA dollars out of the VISN is not seen as accurate since the New England States report the utilization of VA health care has increased. VA figures indicate that VISN 1 now serves 4,483 more veterans than in 1995. Many believe this is due to the fact that poorer, older and chronically ill veterans that make up the mainstay of VA users in VISN 1, do not have the physical of financial wherewithal to move to the southern climates.

The 1994 Statistical Brief on VA Medical Market Share Among Service-Connected Veterans (SCD) confirms this trend. "The market share among SCD veterans increased with each successive higher disability rating reaching 69% among those with a disability rating of 50% or above". Further observation of SCD veterans who are Medicare eligible revealed that only 10% relied on VA for total care compared to the 45% utilization by non Medicare eligible SCD veterans.

Another interesting finding which has not been mentioned are the rates of death. In the Medicare eligible veteran population there was a 10% decline due to death compared to 3% in non Medicare eligible veterans (Hisnanick, 1994). This finding challenges the basic VERA premise that older more traditional "Sunbelt Veterans" would rely on VA for health care and therefore need more resources.

VERA was designed to address the disparity among regions of the country with regard not only to the consumption of resources per veteran but to also take into account adjustments for regional differences in labor costs, educational support, research and maintenance.(VA,1997) There is a far bit of difference in the cost of one day of nursing home costs in CT ($ 222) versus Mississippi ($ 80) in VISN 16 which received more clinical care dollars than any other VISN ($ 1,029,405,652) in FY 1997.(NEPEC, 1997)

VA Capitation Model

Under the present system there are two categories of reimbursement, basic $2,596 and Special Care $ 35,707. Special Care Patients are defined as being Transplants, Chronic Mental Illness and Special (Spinal Cord Injury, Rehabilitation and AIDS) (Kizer, 1997). Realistically all veterans do not fall into two categories. The considerable variation in this range is somewhat imprecise given the status of health care delivery systems in America today. This stratification actually penalizes facilities which care for veterans with chronic illnesses and does not take into consideration variations in acuity of care index.

Clinical Care Dollars

During FY 1995-1997, the percentage of allocated Clinical Care dollars actually used for Clinical Care has decreased in every VISN. This number ranges from a decline of 8% in VISN 15 (81% used for care to 1.2% in VISN 19 (83.9% used for care). Most interesting, VISN 21 reports using only 76.7% of its Clinical Care dollars for that purpose. (NEPEC,1997)

Reserve Funds

In Dr. Kizer's Prescription for Change, he stated that the "For FY 1997, the most any VISN would be reduced would be 1.26% or 5% on an annualized basis. In the initial budget reduction, VISN 1 took more of a cut (1.26%) than any other VISN. There is also the issue of reserve fund of 2% of total VISN budget at the network level to provide management with the flexibility to make business decisions on the best way to manage their assets and resources. Additionally, a headquarter reserve will also be maintained to assist networks that encountered difficulties. The size of that reserve is set at $ 100 million. It is important the substantive guidelines for how those funds are disbursed and accounted for be developed to insure fairness in the distribution of these reserves.

Another area of concern is Medical Care Cost Recovery Funds (MCCF), there are many unanswered questions about how a Medical Facility or VISN may use these funds. I would like you to consider

a situation we have encountered in Connecticut. It has been reported that funds which were recovered through Third Party Reimbursement by VA Connecticut were diverted to the VISN instead of the facilities which provided the care that earned the award of the additional funding. When the funds were eventually returned to VA Connecticut, we learned that the budget for the State was decreased by the exact amount of the MCCF. Ultimately, programs will have to be cut. Staff will have to be cut. Veterans who came to VA Connecticut with their Insurance reimbursement may be among the patients who will not receive care.

There is something inherently wrong with a system that takes money from Priority 2-7 veterans and cuts programs to Priority 1 veterans because of the potential for additional funding sources. Eligibility reform is being sacrificed for additional funding streams. There are reports of several "Gaming Strategies" with carrying over MCCF money from one year to another, investing MCCF funds for additional programs. I would ask Congress to execute the spirit of the original plan to assure that MCCF stays where the care is provided and that facilities not be penalized for providing that care by reductions in budget.

VISN 1

Since 1995, only 3 of the nine VA health care facilities in VISN 1 have appreciably increased the number of veterans served. (VA CT., Providence and Togus.) In fact of the nine hospitals in the VISN, VA Connecticut alone accounts for 28.3% of the increased service to veterans. At the same time, every one of the nine hospital systems in the VISN reports using less of their allocation of Clinical Dollars for patient care.

For example,in FY 1997, Northampton used only 73.7% of dollars allocated for clinical care for that purpose, followed by 76.2% in both Togus and Boston hospitals. Although there has been some variation in these numbers, no facility in the VISN has reported an increase in the percentage of their utilization of clinical dollars for patient care in the last three fiscal years.

There is also a wide variation in the per capita expenditures by facilities in this VISN from $8,129 at Bedford in FY 1995 to $ 3,266 at Manchester New Hampshire. Bedford has remained the costliest hospital within the VISN ($ 7,570 in FY 1997) and now ranks as the 4th most expensive VA hospital in America. Additionally, Bedford has consistently lead the VISN in length of inpatient stay. (Table 1)

Table 1
Average Length of Inpatient Stay VISN 1

Site	1996	1997
Bedford	67.2	60.2
Boston	12.6	11.4
Brocton	20.5	19.4
Manchester	8.8	6.7
North Hampton	38.1	31.1
Providence, RI.	8.9	8
Togus, ME.	11.9	11.2
VA CT.	15.4	11.9
White River JCT.	9.3	8.8

VA Connecticut

In 1993 Newington and West Haven VAMCs were serving more veterans than any other VA hospital in the region including all of the Boston area hospitals. At that time, 44% of the CT hospital workload was veterans being treated for Service Connected Disabilities which compared to 39% service connected veterans in the Boston area and an overall average of 36% for facilities which now comprise VISN # 1. Historically VA CT has not received it's "Fair Share" of funding. Data from 1993 to 1997 reveal a consistent decline (22.99%) in funding and a 4.4% increase in the numbers of veterans served. (Table 2)

VA CT. has been the leader in consolidation of Clinical and Administrative services in VISN 1. There is much to be proud of in the creativity and ingenuity that has become the expected contribution of this state. Long before there was any attempts to consolidate services in Boston, VA CT. was functioning successfully. VA CT. has earned national recognition for the Community Support and Homeless programs. At the same time, we have seen that veteran consumers indicate less satisfaction now than they did in 1995.

Table 2
Funding Levels VA CT.

Year	Funding Level	Difference	% Difference
1993	$ 180,707,562		
1995	142,599,468	$ - 38,108,094	-21.9
1996	137,597,216	- 5,002,252	- 3.5
1997	139,828,335	+ 2,231,119	+ 1.6
1998	133,828,335	- 6,000,000	- 4.3
Totals		$ - 46,879,227	- 28.1

The suggestion that there can only be one tertiary care hospital in a six state region, flies in the face of the standard of care Americans, even veterans, deserve and have come to expect. Recovery of third party payments by VA CT. has been the best in the VISN and in keeping with the spirit and goals of the new VA. Veterans bringing in these funds and choosing VA as their provider will expect that those dollars be available to fund the proper care they need effectively and expeditiously.

Most disappointing is the VISN 1 Network Strategic Plan Summary which projects the implementation of the consolidation of Boston hospitals at year '99-00 while talking about reducing VA CT now. One would hope that the changes in Boston will free more resources for the VISN and allow VA CT to continue its effective and cost efficient care of Connecticut's veterans. Perhaps the most prudent course of action is to freeze any further cuts in VA CT until Boston refines it's system. Then we will better know how the rest of the VISN "fits" in the system. There is no reason to compromise VA CT's capacity to care for VA eligible veterans until that time.

Per Veteran Expenditure by Medical Care Facility

Location	1995	1996	1997
Bedford	$ 8,129	$ 7,959	$ 7,570
Boston	3,628	3,475	3,490
Brocton	6,213	5,552	5,864
Manchester	3,266	3,389	3,272
N. Hampton	4,512	4,176	4,204
Providence	3,458	3,588	2,632
Togus	3,766	3,703	3,583
VA CT	4,764	4,400	4,491
Wt River Jct	3,590	3,581	3,495

Veterans Served by Medical Care Facility

Location	1995	1996	1997
Bedford	9,211	9,452	9,417
Boston	35,348	35,352	35,131
Brocton	22,906	23,276	22,345
Manchester	11,379	11,350	11,481
N. Hampton	10,735	10,963	10,446
Providence	15,892	15,492	20,267
Togus	16,093	16,458	16,705
VA CT	29,903	31,275	31,963
Wt River Jct	12,846	12,889	12,745

Mr. SHAYS. I thank all of you. You could almost end with that and not even ask any questions. It's been a powerful panel. All of you have made a wonderful contribution.

What I wrestle with as a public servant is that you have to look at numbers because numbers ultimately determine what kind of resources you have to serve. I look at the concept of opportunity cost. Opportunity cost for me is if you use a resource here, you can't use it there. So I want to encourage the VA to look at why it would spend, why you would have a 60-day stay in one area and 12 in another. Then in my mind I say my gosh, if you can reduce the stay somewhere else, think of all the wonderful services you can provide so that you are never put in a position, Dr. Woolett, where you have to see someone in such a pathetic physical condition and not be able to respond to that person.

Mr. Williams, your story of the incredible delays in service. What I wrestle with is at any hospital, you want to make sure that you are utilizing the service so that you are maximizing its potential. So should I make an assumption that in Maine, given the population, not the distance, that there are some services you won't be able to provide efficiently and effectively, but that you could provide them well in Boston. And then should I try to in a breakthrough thinking kind of way think of actually flying veterans down to Boston or flying them somewhere else, paying for their stay in Boston, and actually realize significant savings by doing that. I mean is the community in Maine open to that kind of dialog? That is one question.

The second question is, or am I misguided in thinking that certain services that are being provided in Maine, that if you did provide them, you would be utilizing it 100 percent of the time. I'll just throw it out to whomever.

Mr. WILLIAMS. Sir, if I may respond to that. We have some excellent, excellent care providers in our State that are not part of the VA system. Larry Preston could have very well been treated at Eastern Maine Medical Center in Bangor or Portland, ME, but that didn't happen. We have excellent care providers there. We don't have, as veterans, access to those providers.

Mr. SHAYS. So what I am hearing you say is that in cases where you have wide distances and maybe not the density of veterans in terms of the numbers, that the VA needs to and Congress needs to encourage the VA to provide the flexibility to fund them at private facilities.

Mr. WILLIAMS. Sir, that is what you hear me saying. But on a practical level, the same care at a VA facility is much less costly than it is at an outside facility.

Mr. SHAYS. Provided you have the——

Mr. WILLIAMS. We need money.

Mr. SHAYS. Pardon me?

Mr. WILLIAMS. We need money.

Mr. SHAYS. I know you need money. I know you are not here to say you don't need money. I am just trying to say that I made an argument in Connecticut that someone shouldn't even have to go an hour to New Haven, West Haven, if they can get that service in Stamford. Now what we have, and bless the heart of the VA, they have really worked hard to get outpatient clinics. In fact, even

stretching the law and pushing the appropriators, because in some cases they open these facilities without a signoff on the part of legislators, but they pushed us.

My only point is that in response, veterans like their VA hospital. They like the fact that in a VA hospital you are recognized as someone who has risked your life. You don't always necessarily feel that in a private hospital. But I am just looking at tradeoffs here. I am looking for a solution. I don't want to just have a hearing, hear some rough stories, and beat up a little on VA, and then walk away and say we did our job. I know that's what Mr. Allen wants as well.

Let me hear your comment, and then I am going to recognize Mr. Allen.

Mr. Bachman.

Mr. BACHMAN. Congressman Shays, I guess I could put it to you in this respect as not only a veteran but as a clinician there. Probably the most significant thing when you treat a patient, when you have done whatever you are going to do to him or her, there is a time of care, time of recovery that has to be done. That recovery needs to be as close to the family as possible to expedite that recovery for any patient. If you ask the question whether Togus VA needs to have open heart surgery, as a clinician I will tell you no. It is not needed there. There are some things that the VISN's as the center of excellence needs for the entire VISN's.

But when you look at and have to manage something the size of VISN–1, there has to be an area where you say because of where that situation is and where those veterans are, can you provide better care at that facility. I think the main problem that occurred is when we stuck toward managed care within the Veterans' Administration, we looked at managed care the way everyone looks at managed care in the civilian population, where the maximum of it is 10 to 20 percent adverse risk population, and 80 percent are the working well. That is just the opposite at most Veterans' Administrations that we do today; 80 to 90 percent of those patients are adverse risk. They are seriously ill. They have used the Veterans' Administration for everywhere as their safety net to provide them with the care that they need because they don't have insurance, they don't have employment or anything else. Congress created that safety net for them many years ago. Now we are trying to remove that safety net from them.

But what we did, sir, when we went this way, no one took apart the old infrastructure. In most VA's today, you have a VISN level management level and you have the hospitals with their management level. We didn't do anything. We created another management level is what we did. That money had to come from somewhere. Could it have been spent better?

Mr. SHAYS. That is a very important question and very valid comments. I just fear, I have been in Congress now 11 years, sometimes when we don't want to say no to someone, we just let it wither. Just as the Post Office has approximately 800,000 employees, they are going to have to get to 500,000 to be able to compete or else ultimately there will be other ways that people get service instead of the Post Office. Maybe it seems like a sad analogy, but I believe that in my own community in the lower part of my district,

we have four hospitals, not VA hospitals. We have studies that say we only need one. We only need one. Now we can keep all four open. But in the end, we are going to provide worse service because every one of them will be on a shoestring. So that's what I am having to debate in terms of how I respond to what I am hearing.

But I don't want, I would never want to hear a story and know that that happens and I was a part of it, where you had someone come in the condition and that you had to provide the service, and that you had the story that you had to tell. I mean they are horrible stories. So we'll sit down together and my staff will work with you and I know Mr. Allen's staff. We'll be working with the VA on how we can respond to this. We're not going to wait for a report. We're going to be in communication.

Again, I want to thank Dr. Garthwaite for being here and Dr. FitzGerald, and Mr. Sims, and Mr. Ng for staying.

Thank you for your patience. You have the floor.

Mr. ALLEN [presiding]. Thank you, Mr. Chairman. I know from talking to my friends from Maine that we all got the tip of the iceberg in terms of the stories that they could have told about problems with the delivery of healthcare services. As we have gone through this process, one of the things that has lead me to have some sympathy for all those in the VA is I recognize that you have not an infinite pool of people to serve out there, but a pool that keeps expanding. You could keep going to more and more veterans who are service-connected or to veterans who have lesser degree of illness or injury because of a service connection.

I want to thank all of you very much. What you have said today is extremely important. It will help us in our deliberations.

I want to end basically by coming back to something that Dr. Garthwaite said. It really has to do with back to the system. I am groping as is Mr. Shays for solutions, for approaches that might make some difference. Listening to Dr. Schwartz, listening to Dr. Garthwaite earlier, it strikes me that when you were describing, Dr. Garthwaite, the variations in costs around the country and how you were trying to account for the known costs, and when you were done accounting for all the known costs, there was still a variation. And that one of the things you were trying to accomplish was to use Federal dollars efficiently. We're all for that.

The underlying assumption of the VERA system in a reallocation of money is that you can perhaps create a negative incentive by moving that money, that there will be changes made at the more expensive, in the more expensive areas. But I wonder if the difference in expense isn't related to a mode of practice, but has to do with something that we haven't quite been able to account for by the numbers.

I find it a little difficult to believe that we can't somehow have the same level of management in the northeast as in other parts of the country. It strikes me that what we may have done is not really to create much of an incentive or a successful incentive for more efficient management. We have simply hurt more veterans. It's that that we need to address and deal with.

I appreciate the complexity of your job, but I also know what I am hearing from people in Maine. The veterans in Maine are not getting the services that they deserve. Partly it is probably there

just isn't enough money in the system. Partly it is probably because of inefficiencies in management or you can have a variety of different reasons.

But what I would ask the VA is take another look at this VERA system. In light of what Dr. Schwartz has said, question the underlying assumptions that we walked into this system with. See if we can't figure out a way to make sure that we aren't really hurting some veterans in parts of this country that are being hurt more than in other parts. See what we can't do.

This is an ongoing process. All of you played a very important role in it today. He's had to leave, but I really appreciate Chairman Shays holding this hearing.

With that, we are being called to a vote. So we have to conclude.

Oh, Congressman Baldacci has reappeared. I guess what I would like to do is give him, if you have any closing comments, I would be glad to.

Mr. BALDACCI. Sometimes I think that people can hear me without turning the mic on, so I apologize.

I want to thank Congressman Allen and the subcommittee and the staff for their work. I want to thank all of you for being here. I enjoyed reading your testimony and would like to continue to go over it because I know 1 day does not change the way things are. We need to continue to work together as we move forward. I want to thank you all for being here. I know what a sacrifice it has been.

Neal, I appreciate your being here and representing the veterans, and speaking I'm sure as eloquently as always. So I enjoy working with you and will be working with you and also in trying to make sure that we followup on the issues that were raised.

I want to thank you for this opportunity. Thank you very much.

Mr. ALLEN. Thank you. With that, this hearing is adjourned.

[Whereupon, at 1:43 p.m., the subcommittee was adjourned, subject to the call of the Chair.]

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