FIELD HEARING ON QUALITY OF CARE AND MANAGEMENT ISSUES

HEARING

BEFORE THE

SUBCOMMITTEE OVERSIGHT AND INVESTIGATIONS

OF THE

COMMITTEE ON VETERANS' AFFAIRS
HOUSE OF REPRESENTATIVES

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FIELD HEARING ON QUALITY OF CARE AND MANAGEMENT ISSUES

WEDNESDAY, SEPTEMBER 5, 2001

HOUSE OF REPRESENTATIVES,
SUBCOMMITTEE ON OVERSIGHT AND INVESTIGATIONS,
COMMITTEE ON VETERANS' AFFAIRS,
Washington, DC.

The subcommittee met, pursuant to call, at 10 a.m., in the Indiana War Memorial Auditorium, 431 North Meridian Street, Indianapolis, IN, Steve Buyer (Chairman of the subcommittee) presiding.

Present: Representatives Buyer and Carson.

OPENING STATEMENT OF CHAIRMAN BUYER

Mr. BUYER. The hearing will come to order. Good morning to everyone, all the guests in the audience today, and also the Secretary of Veterans Affairs, Tony Principi.

The Oversight and Investigations Subcommittee field hearing will examine access and quality of health care and delivery of benefits to Indiana veterans as we also examine the VA as a system.

This is the subcommittee's first field hearing and I would like to thank my colleague, Ms. Julia Carson, the subcommittee's ranking Democrat Member, for her presence and her keen interest in also serving the needs of veterans.

I would also like to extend a warm welcome to Secretary Principi for coming to Indianapolis to this subcommittee hearing. Generally, it is unprecedented for one of the President's cabinet secretaries to appear before a subcommittee. Generally they testify before the full committees in the U.S. Senate and in the House of Representatives. Secretary Principi's dedication to the issues we are going to address today—I believe his presence exemplifies his spirit and his enthusiasm in tackling some very difficult issues. It is my privilege, also with Ms. Carson, to welcome you, Mr. Secretary, to our home state of Indiana.

The State of Indiana and the City of Indianapolis is the home of the American Legion national headquarters and Indiana has always been proud of our men and women who served and those who proudly wear the uniform in today's military.

President Bush, a veteran and military pilot himself, made commitments to our Nation's veterans last year and Secretary Principi, you have taken on the task of tackling those challenges and turning these promises into VA policy. I believe, Secretary Principi, that you have exhibited your commitment to once again making veterans a priority in this department of the government. I know that one of your highest priorities is attacking over 600,000 claims

backlog that you inherited from a previous administration. There have been comments from some that have sought to blame you, Secretary Principi, for the claims backlog. I believe that that exhibits either ignorance or political partisan venom that is inexcusable. I understand that your VA claims processing task force is currently conducting a top to bottom review of the VA's benefits processing.

This committee looks forward to reviewing the findings of this task force and will strongly support your efforts to speed up the processing of claims and increase the accuracy of those decisions. Mr. Secretary, the subcommittee stands ready to assist you in this endeavor. Simply put, no veteran should have his or her claim delayed or lost in the bureaucracy and no veteran should die before his or her claim is adjudicated. I also look forward to supporting Secretary Principi in the Pentagon's major reform efforts to improve cooperation between the two largest federal departments in providing health care and benefits to those who have served and those who are serving in today's military.

In addition, Secretary Principi, the subcommittee will hear testimony from the VA's Inspector General and Indiana's working veterans' service officers, to include senior VA healthcare and benefits representatives and labor union partners representing VA's employees in the state of Indiana.

It is also—I do not want to say unprecedented, but not often do we ever get to hear from those veterans' service officers who work in those county courthouses all across the country, and that is the reason that this subcommittee has asked them to be here. As you said last night, they are on the front lines and in the trenches. So we are going to hear their perspective today.

I look forward to hearing today's testimony and the answers of our witnesses to the subcommittee's questions. I also would note, Mr. Secretary, you had an opportunity to meet the gentleman last night, but he is in our audience today and we have a World War I veteran who is present today and his name is Gus Streeter. Mr. Streeter, we welcome you today to the Memorial dedicated to end all wars that you fought on foreign soil, and we appreciate your presence here today. (Applause.)

There is also one other gentleman I would just like to note and if I may give a little background on him. I note that an individual is here that Ms. Carson knows very well, Mr. O'Donnell is a survivor of the USS *Indianapolis*. In the spring of 1999, I was visited in my office in Washington, DC by a producer and director from Hollywood. They wanted to make another film about the USS *Indianapolis*. And what I told the director was—he wanted access to the Pentagon and all kinds of different things, to make this film and I said, you know, I have seen and I think American has seen many different movies about the sailors in the water and that tragedy, yet at the same time their indomitable spirit to survive. But no one has ever focused upon the contribution of the sailors and the ship during World War II to end the war.

So I spoke with the then chief Naval officer, Jay Johnson, about getting an award for the ship so that the sailors also received their awards. I wrote that in the law in the 2000 defense bill. So I was very pleased when the Assistant Secretary of the Navy came to Indianapolis, Mr. Secretary, last month and awarded to some of the

families and the living survivors of the USS *Indianapolis* the awards that they should have received decades ago. But we have sought to right a wrong and I am very pleased—and that gentleman is also here today, Mr. O'Donnell. It is a pleasure to have you here. (Applause.)

I now recognize Congresswoman Julia Carson here of Indianapolis, our subcommittee's ranking Democrat member.

OPENING STATEMENT OF HON. JULIA CARSON

Ms. CARSON. Thank you very much, Mr. Chairman.

First and foremost, let me say that I am very honored, I am very grateful for all of the veterans who are assembled here today at the World War Memorial, and to say that I give you another standing ovation—as a matter of fact, an eternal one for your selflessness, for your bravery, for ensuring that we maintain the land of the free and the home of the brave. You are recognized too little, and anything that I can do to uplift the lives of those who fought for me even when I did not know about it, I want you to know how very grateful that I am.

I also want you to know, Mr. Streeter, 104 years old, that there are at least 104 reasons why this Oversight Subcommittee should ensure that veterans' benefits are expedited, that their claims are expedited, that it does not matter what partisan political power play one might decide they want to utilize, the bottom line is taking care of American veterans. I do not care who is in the White House or who is in the U.S. Congress, we should not play political games with those who have fought hard for us. And as long as I am in Congress, I am going to do whatever I can do for the benefit of those who fought for me and I want to give you my personal gratitude, Mr. Streeter; thank you so much for being here today, thank you very much for accepting my invitation to come.

And you, Mr. McDonald, you are a jewel. I met some of the survivors who came to Washington, DC at the airport when they got off the plane. I was so excited, enthusiastic about their visit to Washington, DC. They were accompanied at that time by a young man from Florida named Hunter Scott, who was in Congressman Scarborough's district. Congressman Scarborough and I introduced legislation to vindicate Captain McVeigh and the rest of the crew who, under very trying circumstances, were unable to save the USS *Indianapolis*. I was contacted because I am from Indianapolis, elected from Indianapolis and they thought that would be a fitting tribute.

And I would probably get in trouble today, I would get caught, but Hunter Scott, at the time was an 8-year old white kid, wonderful kid. I took him on the floor of the House and told the doorkeeper he was my son quickly. (Laughter.)

And let him drop himself the bill that I introduced in behalf of the USS *Indianapolis*. So I did not get caught in time, it was already done when they realized I had tricked them and allowed him to come on the floor.

So I want to quickly say how grateful I am to the Secretary of the Veterans' Administration for being here in Indianapolis today. It is not ordinary that a person of his background, his prestige, his power would take the time to come to Indianapolis, but I think he

has been so excited about our landscape and our hospitality that we probably will not have a hard time getting him to come back again. So Mr. Secretary, Mr. Principi, thank you so very much for being here.

We have gone through the Roudebush Medical Center this morning. We trust that we can review the performance of the one VA initiative, not only within the great state of Indiana, but nationwide as well.

I am sure that you join me, Mr. Buyer, who chairs this very challenging but necessary oversight committee of the House of Representatives, the VA Subcommittee on Oversight, in acknowledging the tremendous contributions that our veterans have made and that they will continue to make. We have many veterans in the audience, I see representatives of the veterans' services organizations.

At the hearing today, I look for balance among the programs serving our veterans. I look to bring out those best practices that deserve the widest possible dissemination and to publicly applaud those leaders responsible for the success. The very best of programmatic success stories must get the widest possible dissemination. These are the best practices that should be shared with the "One VA."

I also understand that in any large diverse geographically dispersed organization, problems in efficiencies may occur. It is part of our oversight role to identify areas of concern, shine light upon those concerns and see to it that either the problems are corrected, or that we fully understand the circumstances that appear on their face to be problematic. Where inefficiencies and substandard care or service exist, we must first shed light and then chart a path for correction. Veteran after veteran this morning at the VA Hospital were very complimentary of the services that they receive at the VA Hospital. And I am sure they were not orchestrated to make those statements because the VA's Secretary was here. I could tell they were very sincere. They probably got a better meal this morning because they were very happy about the meal that they were served, but beyond that, everybody was very complimentary about the services that they got at the VA Hospital, those who were in the hospital there. And I was very pleased again to hear that. I go out to the Veterans' Hospital on a very regular basis.

Let me close by saying that our latest information shows that Indianapolis Regional Office exceeds the national average of other regional offices in 13 of the 14 performance measurement criterias used in the VA's scorecard approach to benefits delivery. While it appears that the performance of the Indianapolis Regional Office is far better than most, a large backlog of pending claims do remain. We are also mindful that while the VA strives to accelerate the benefits rating process, they must not lose sight of the core element that our veterans, when they present their claims, deserve America's respect and must be treated with dignity.

In healthcare, we see many strong improvements. For example, community based outpatient clinics, or CBOCs, have increased access for veterans into the VA healthcare system pipeline. There are many premier innovative programs at the Richard L. Roudebush Medical Center in Indianapolis, such as the precise stereotactic radiation therapy program. We applaud the push toward high tech-

nology treatments, but let us not forget the need for simple outreach and counseling for veterans affected.

Mr. Secretary and Mr. Chairman, let me mention, we are concerned about the rationale behind some management decisions impacting our veterans in the Northern Indiana Healthcare System. For example, we note that on October 20, 2000, less than a year ago, we had a 100-bed, state-of-the-art, multi-million dollar, general psychiatry building dedicated at the Marion campus. Perhaps, Mr. Chairman, you were present at that dedication. We now understand that there is a change implementation plan calling for a reduction of 25 beds before October 1 of this year and that another 25 beds may be closed by the end of this calendar year. That means that a facility built at taxpayers' expense for 100 patients will be operated at half capacity within 15 months of its dedication. That is a shame. Is this bad planning or are we using Draconian measures to reduce costs at the expense of veterans needing care?

Today, Mr. Chairman, I anticipate that we will provide a sounding board for numerous best practices. I also hope we gain a full understanding of specifically how, when and to whom notice has been given for any proposed changes that potentially have negative impact on the care of our veterans, such as the Marion facility.

Thank you very much, Mr. Chairman. (Applause.)

Mr. BUYER. Mr. Secretary, you know, we had an opportunity to tour this facility and I did not share with you, my father is a Korean War veteran, but my grandfather was a World War I veteran, so I could not help but sense as we toured here and we toured the shrine room, that not only Mr. Streeter, but my grandfather, his comrades and their families helped build this war memorial to end all wars, and it is a proper venue. I think I look back and hopefully Mr. Streeter and my grandfather, I think we are giving them the compliments that they had hoped that in the future, someone of your stature, sir, would be here to testify about the system and how our country in turn is treating our veterans. So this is a proper venue and forum for this hearing today to receive the testimony from the Secretary of the VA.

Let me conclude by saying that when you look around, you see that the art of man is able to construct monuments and awards that are far more significant than the narrow span of our own existence. So you have to examine the contributions that we do with the time that we have. And when veterans lay it on the line for our peace and security, the responsibility that not only you have, Mr. Secretary, but that which we share, Ms. Carson and I and others on the committee, to ensure that those commitments are fulfilled. That is our solemn duty.

With that, I yield to you for your testimony.

STATEMENT OF HON. ANTHONY J. PRINCIPI, SECRETARY, DEPARTMENT OF VETERANS AFFAIRS

Secretary PRINCIPI. Thank you, Mr. Chairman and Honorable Congresswoman Carson. Thank you for the kind invitation to be here. I am honored to be with you at this field hearing and I certainly agree that this is a fitting place to have a field hearing, this magnificent war memorial, as this is the first time I have had the chance to tour. As we did to VA earlier today, I reflected on the

images and the photographs of the war weary soldiers and sailors and airmen and marines who fought in our Nation's wars and as you touch the artifacts, I am reminded what my department is all about. It is about caring for the people who have given so much in defense of freedom and liberty in this world, and to stand in this magnificent shrine just off this auditorium, I was touched by the words inscribed in gold in the shrine, I think it says it all. "In the stars of our flag shines the steadfastness of the stars in heaven. They light the path of men to courage, devotion and patriotism." And indeed, the 25 million men and women, living veterans, the 1.5 million who have given their lives in defense of freedom and the millions of others who have been wounded in battle deserve our utmost attention and our utmost compassion. And that is one of the reasons I feel very blessed and honored that the President looked to me to embody his commitment, the commitment of the American people to those who have served.

I welcome this opportunity to appear before the committee, I thank the committee for the tremendous support that you, Mr. Chairman, and Ranking Democratic Member Carson, have given to my department and to the veterans we serve and for your willingness to discuss my goals for VA because the achievement of our national goals, I believe, will have a direct effect on VA's services and benefits for the veterans of this great state.

Our goals, based upon my five-part vision for VA, encompass healthcare, benefits, medical research, our national cemeteries and VA's business practices. No one goal can be achieved in isolation—VA's future success requires an integrated plan of action.

VA is no longer the brick-and-mortar monolithic institution that it once was. And that is as it must be. Quality of care and management issues at Richard L. Roudebush VA Medical Center and across the landscape of the Northern Indiana Health Care System require an integrated and flexible plan of action—an action plan that can address multiple conditions simultaneously across the entire VA network.

This is the 21st century. Veterans have become accustomed to computers that multi-task; to delivery services that send packages around the world in hours, not months to get a medical record from one agency of government to the other; and to getting answers to questions at the press of a key, not being left on hold for hour after hour while you wait for answers to your questions.

Indiana's 573,000 veterans have earned the right to access a 21st century-capable network of care and services from VA—and they should not have to accept anything less than timely, compassionate and effective delivery of such care and services.

In the past few years, I am proud to say that the people of VA have dramatically transformed the VA health care system. Our Veterans Health Administration has moved from an impatient model of care, characterized by a limited number of large facilities oftentimes at great distances from veterans' homes, to an outpatient model providing veterans with care at over 800 new primary community-based outpatient clinics.

Today, we provide better quality of care than ever before. And as we witnessed this morning at the Medical Center, veteran after veteran talked about the high quality of care, as Ms. Carson men-

tioned just a few moments ago. With 27,000 fewer employees, VA provided care to about 930,000 more veterans across the country in 2000 than we did in 1993.

I am committed to seeing VA become the Nation's recognized leader and I underscore the words, emphasize the words "recognized leader" in providing high quality health care to a clearly defined segment of the American population—the people who have earned that care through their service in uniform. In particular, I want us to lead in areas where we have a unique role to play in health care—spinal cord injury, blind rehabilitation, care for those with serious mental illnesses and, of course, geriatric care with the aging of the veteran population far out in front of the general population in America. We need to make an investment in our specialized programs and we need to be profiled for the excellence that we provide in those areas.

The Northern Indiana Health Care System, comprising the Marion and Fort Wayne Medical Centers, and its community based outpatient clinics in South Bend and Muncie, when coupled with the Roudebush Medical Center and its two clinics at Bloomington and Terre Haute and our regional office here in Indianapolis, responds daily to the broadest range of medical and benefits issues for Indiana's veterans.

Each component of the system contributes a depth of expertise that makes the whole system responsive to the varied needs of Indiana's veterans. Certainly not perfect, but we are improving every day. Whether it is neuropsychiatric referral at Marion, surgical services at Fort Wayne or medical research in Indianapolis, VA has a resource to meet that challenge. Dr. Michael Murphy can present a more detailed picture of the Northern Indiana Health Care System, but I want to stress up front that VA works best when we work together, and here in Indiana, I believe our team is working together on behalf of the veterans of your state.

The Roudebush Medical Center is an outstanding example of what VA is becoming, an unmatched nexus for treatment, rehabilitation and research for America's veterans.

Robert Sabin, our Director, can fill you in on the details of the center's work, but let me say that from AIDS research to prosthetics services which we saw this morning, to homeless veterans' programs and I know we are going to do a ribbon cutting today in town, to cardiac care, this medical center in Indianapolis places veterans at the heart of care and respect.

In keeping with my vision of improving and raising VA's research profile, I am proud that the medical center here is actively engaged in some of the most important research on AIDS, Alzheimer's disease, hepatitis and cancer. But I will stress that our mission is to care for him who shall have borne the battle.

Our research program will be, must be focused on research that helps those who have borne the battle. And I want very much for VA to get the credit and receive the revenues from research discoveries. I become very, very discouraged and disappointed when I turn on the news to hear about a recent medical research discovery done with VA research dollars in VA research laboratories with VA researchers to find no mention of VA in the announcement or any of the revenues associated with that research, the royalties, staying

with VA. If we are to build a constituency and support for our research program, I think it is absolutely critical that VA get the credit and part of the revenues from it, and that is certainly something that we are working hard on. We hired our first patent lawyer at VA and we will take steps to ensure that happens.

Let me talk about the issue of the backlog of claims, which I know is of great concern to you, Chairman Buyer, and Congresswoman Carson, and I want you to know that it is of great concern to me as well. As you indicated, the backlog is now over 650,000 claims, that includes almost 93,000 claims that are on appeal. It is taking too long, much too long, to decide these claims. And we have taken steps now to try to bring this backlog down and I am hopeful over the next several years, we will.

First and most importantly, I am proud that we have hired 1200 new people in our Veterans Benefits Administration, the vast majority of which will be devoted to rating claims. Part of the new hires will, of course, go to education and other programs that we administer, but the vast majority will be devoted to our compensation and pension program. And I believe that we need to increase staff in places like Indianapolis because there is such a tremendous work ethic here and the quality of the work is so high. So I think we need to concentrate our resources in some of the areas like the heartland of America, places like Indianapolis, where we have such a tremendous record of success and productivity. I certainly commend the leadership of our regional office here for the work they have done.

Secondly, I have created a claims processing task force headed by Admiral Dan Cooper, who recently retired as our Commanding Admiral of our nuclear-powered submarine forces, to do a top to bottom review of our claims system. He brings great leadership, great focus and great intellect, to this work and I expect his report on my desk the first week of October. I have asked for practical hands-on solutions. I am not interested in abstract theories of veterans' benefits or how we can curtail benefits and thereby reduce the backlog. I want solutions to how we are organized—our procedures and our processes, in order to move these claims through the system more timely while maintaining a high degree of accuracy.

Most recently, I created a Tiger Team in response to the President's direction. This Tiger Team, which is headquartered out of Cleveland, OH, with nine other sites around the country, will take on the claims that have been languishing over a year by veterans whose age is in excess of 70 years old. There are 8,000 claims now filed by veterans who are currently over the age of 70, many approaching the age of 80, and unfortunately too many of them are passing on before their claims are decided. I think that's a national tragedy and I am hopeful that the Tiger Team will be able to address those claims in an expeditious manner.

My vision for VA includes recognition of national cemeteries as national shrines. Health care at the Roudebush Medical Center can help Indiana's veterans achieve the best possible life. But when a veteran dies, he or she must be accorded the highest honor the Nation can bestow. How we care for our veterans in death says much about our Nation's respect for their lives.

And finally, Mr. Chairman, let me address for a moment my fifth vision, that VA must use sound business principles to accomplish our mission. It is as simple as this—I do not like leaving money on the table because every dollar we waste is a dollar out of a taxpayer's pocket, it is a dollar that we do not have, to extend the reach of health care and benefits delivery, because we have wasted that money.

Annually, we procure over $5 billion in goods and services around the country. I am absolutely confident that with sound business practices we can reduce the amount we spend and use those savings to increase health care and benefits delivery.

I have ordered an acquisition reform task force to address much needed reforms in our acquisition programs and I have charged my Chief Information Officer with not procuring any new information technology systems until we adopt a comprehensive, integrated enterprise architecture that ends stovepipe design and development of information management systems.

Mr. Chairman, Ranking Democratic Member Carson, that concludes my testimony. I would be pleased to try to answer any questions you might have. Thank you.

[The prepared statement of Secretary Principi appears on p. 48.]

Mr. BUYER. Thank you, Mr. Secretary. We are going to go right into it.

Yesterday, the Under Secretary for Benefits resigned and his deputy also resigned. There was a temporary reassignment of the regional director in Atlanta. So all I can get is what is on the President's news wires. Can you help explain here to this subcommittee what is going on?

Secretary PRINCIPI. Yes, Mr. Chairman. It was a very, very difficult weekend. Last week, it was reported that one current employee and two former employees at the VA regional office in Atlanta had allegedly fraudulently stolen over $6 million through manipulating the system with regard to compensation and pension claims. The case is still under investigation in Atlanta. Our Inspector General, who has worked very, very diligently on this case is here today, so I cannot comment on the specifics of the case.

However, this is the fourth instance in 2 years wherein we have had similar type problems. And I believe that it was critically important that I take decisive management steps to address this problem. Accordingly, I have asked the Inspector General to take the lead in developing a methodology and plan for conducting an immediate review and audit of certain financial information, basically compensation and pension tapes that are forwarded to the Department of Treasury for payment, to determine whether there are other potential problems in our system.

I have also directed my Chief Information Officer to look at electronic safeguards that can be implemented in the short-term to ensure that this kind of alleged criminal activity can be prevented, and if not prevented, at least identified so that we can take appropriate management action, or investigative action by our IG.

I also believe that all of us must be held accountable for our actions. Without accountability, our ship will continue to run aground, our programs will continue to falter, people will lose confidence and credibility in our systems. And I believe that there was

a failure on the part of VA leadership to ensure that programs and policies were in place, that recommendations were sufficiently implemented that could have possibly identified or prevented this activity from occurring.

Six million dollars or seven million dollars of taxpayer funds that are entrusted to my department for care of veterans, their widows and their orphans was stolen. That is appalling and shocking to me; accordingly, the Under Secretary offered his resignation, as did the Deputy Under Secretary for Benefits. I detailed out of Atlanta the director and the assistant director, pending a complete investigation. None of the officials I mentioned are in any way involved in any criminal activity, these were management decisions that were taken pending the completion of all ongoing audits and investigations.

Mr. BUYER. Thank you.

In your—on the issue of claims backlog, you mentioned that you have taken steps. Would you be a little more specific as to what steps you have taken. And then you immediately jumped into talking about your tiger teams. What steps have you taken for then the under-70? Are you hiring more people, are you streamlining a process? What exactly are you doing?

Secretary PRINCIPI. Yes. Well, Mr. Chairman, since January 20, we have hired approximately 900 people into our benefits administration. Many of those people have been trained, others are in the training pipeline that will be completed in October. As a matter of fact, in discussions with the regional office director earlier today, he indicated to me that some of his newer people have been trained and are beginning to rate cases. So that is a very, very important step because it takes people to process the cases.

Mr. BUYER. Mr. Secretary, can you sort of break this out for us? It is one thing to hire 900 people, but how many are the real decisionmakers that can help move this process along?

Secretary PRINCIPI. I do not know the precise number. I can provide that for the record.

Mr. BUYER. All right. But they will—if you could sort of break that down for the committee, it would be very helpful to us.

Secretary PRINCIPI. Yes.

Mr. BUYER. Between the raters, administrative support and decisionmakers.

Secretary PRINCIPI. Because a lot of the claims backlog relates to claims development, it is getting the files from the Defense Department, going through those files, ordering a medical examination, getting the results, analyzing them, doing the claims development work, and then getting it to the rating specialist to actually rate the claim.

So throughout the process, we need to look at the work flow and the time it is taking for us from the intake, the control, the claims development and the actual rating. We are hiring people to fulfill each step in that process. But in the final analysis, it is about rating claims, it is about making decisions, it is about performance standards. And I think that is what we need to work on.

Ms. CARSON. I wonder, Mr. Secretary—this is an idea I had as I heard you speak—what would be the feasibility of hiring persons who are veterans who know the process, who know the rating cri-

teria, who recognize disabilities when they see one? Do you know what I am saying?

Secretary PRINCIPI. Oh, I——

Ms. CARSON. Is that a possibility? I mean a lot of veterans are just brilliant people.

Secretary PRINCIPI. Yes, Congresswoman Carson, we do, in fact, hire veterans. As a matter of fact, I have strongly recommended to the leadership of our benefits administration that we hire more people coming off of active duty, especially people with medical backgrounds. A great many registered nurses in uniform who leave when their tour of duty is up and others who have served in the military and now are veterans, we can bring them on, as they have a medical backgrounds and therefore, we can dispense with some training, and we can certify them in the medical component of their training and immediately get them into the complexities of the disability evaluation process. So I agree with you, we should hire veterans when possible. We do. And we should hire more people coming off of active duty.

Ms. CARSON. Who is responsible for the success of the One VA?

Secretary PRINCIPI. I am ultimately, I——

Ms. CARSON. I just wanted to see if you would toot your own horn.

Secretary PRINCIPI (continuing). Am responsible and accountable. But you know, all of us are.

The claims backlog is not a benefits administration problem only. It is also a Veterans Health Administration problem. The regional office cannot rate claims unless they get a quality, timely medical evaluation performed by the Roudebush Medical Center or up in Northern Indiana or in the outpatient clinics. They cannot rate a claim without good regulations prepared by the General Counsel. And they certainly can make their job easier if they have the right information technology systems on their desk to do the job. So this is a VA problem. And sometimes we have looked at it as a Veterans Benefits Administration problem, but it is a VA problem. And I am holding everybody accountable—the leadership of our health side, benefits side, general counsel, information technology and ultimately I am accountable to the veterans for its success.

Ms. CARSON. I am an expert in fraud identification. I saved the township here $20 million in getting rid of all that stuff. Could the situation in Atlanta been averted with a robust security program?

Secretary PRINCIPI. It is hard for me to believe that in the year 2001, in an era of extraordinary advancements in computer technology, that there are not systems that could have prevented this from happening. Now people, greedy people who are dishonest and betray trust can always find a way to steal. Unfortunately, you can always manipulate the systems. But I must tell you I am embarrassed and ashamed that a clerk in a credit union identified this alleged fraud. And had this clerk in this credit union not said something is wrong with all of these deposits, I am afraid this may have gone on.

Again, I should not comment any more on the case because, one, I do not know all the facts yet and I know the investigation is still ongoing. But I agree with you, I think it could have been prevented, and that was one of the reasons for the actions I took.

Mr. BUYER. Mr. Secretary, before I yield to Ms. Carson, I have one last question. From an analytical systems approach, when you mentioned the integration that is occurring and transformation of the VA, you mentioned from no longer bricks and mortar, to more from inpatient to outpatient, can you tell me what is happening out there around the country? When we look here in Indiana, we note that as you move to greater outpatient, that whether it is from the Danville VA and you have an outpatient clinic in Lafayette no longer taking appointments. You have some concerns up at Lakeside in Chicago, where we have a facility, in Crown Point, we have outpatient clinics in South Bend and Muncie affiliated with Fort Wayne/Marion. We have a continuous integration that seems to always occur between Fort Wayne and Marion.

So can you give the committee an idea here what is happening around the country from a health standpoint, health care and delivery of care and access?

Secretary PRINCIPI. Sure.

Mr. BUYER. And before you do that, I know that we, Congress—you know, even though the budgets have been plussed up by $3 billion and another 10 percent, it always comes down to the money. We opened up the VA much greater than what perhaps a lot of us had even thought on the Category 7's, so I know it is not all the VA. We compounded a problem here, Congress did.

Secretary PRINCIPI. Indeed. And I appreciate that, Mr. Chairman.

Clearly, I think we all recognize that health care in America has changed profoundly and continues to change profoundly. What we are capable of doing on an outpatient basis today in years past would have required long inpatient hospital stays. For example, so much of cataract surgery can be done on an outpatient basis. We have also learned that whereas we need to maintain an infrastructure in mental health, and I am a strong proponent of mental health programs because VA has always played a leadership role in mental health, there is so much that can be done today with atypical anti-psychotic drugs. People do not have to be housed in mental institutions. They can live productive and enjoyable lives in the community if we have community-based programs, if we have the appropriate infrastructure and outpatient programs. So I think it needs to be balanced.

I think health care is changing. The advancement with pharmaceuticals has helped a great deal. I am afraid we may be closing too many inpatient mental health beds before we have the outpatient programs in place, and I am concerned about that.

So that is the good news.

The good/bad news is that we are victims of our own success. Quality has improved dramatically. We have opened up all the outpatient clinics around the country, we have the best pharmaceutical benefit program in the country, bar none, and we have been inundated—we have been absolutely inundated by veterans who are flocking to the VA health care system while we are a finitely budgeted health care system. We are not HHS, we are not Medicare/Medicaid. We do not get any money from Medicare or Medicaid even though 50 percent of our patient population are Medicare eligible.

I am concerned about waiting times, I am concerned about the quality of care, I am concerned about the impact of this growth on the service-connected disabled and the poor, because they are our primary base. I want to continue to care for all veterans because there are no low priority veterans in my view. A man who scaled the walls of Normandy and but for the grace of God came back and never filed a claim and may now have a good income, is no lower priority veteran to me than someone who never went to war.

But at the same time, there is only so much that we can do and I have to make some tough decisions on how we deal with the various categories that have been established by Congress. You told me, every year, Mr. Secretary, you have to make a decision on how many of the non-service connected, higher income veterans you can treat. And I cannot treat everybody unless I get Medicare money or something else happens, because it will have an impact on the waiting times. We will ration care or the decision will be made because when a veteran goes to make an appointment, he will not be able to be seen for 6 months or 9 months or whatever. And that is unacceptable. So we have some difficult decisions to make.

But your question is an important one. We have infinite demand and we are finitely budgeted. We are stretched thin today. And, you know, I do not second guess those decisions, I think opening the outpatient clinics was the right decision, I think having the eligibility reform was the right decision. But no one predicted what would happen and what has happened is everybody wants to come and there is only so much room.

Mr. BUYER. So the level of the influx from the Category 7—let me get your testimony here so I can feel it right—the influx, when we, Congress, did this eligibility reform and permitted more Category 7 to access the VA, we never anticipated that utilization rate would be what it is today.

Secretary PRINCIPI. Correct.

Mr. BUYER. And that has placed great stress upon the VA and its service-connected disabled veterans, on their ability to access care.

Secretary PRINCIPI. That is correct. You take Iowa, for example, in Iowa City, the growth in Category 7's between 1998 and 2001 has been 2300 percent.

Mr. BUYER. Wow.

Secretary PRINCIPI. We have grown since, I think it was 1998 or 1999, overall, we had 300,000 veterans who were Category 7's, today we're almost up to 900,000, who are enrolled and receiving care in VA. Many do come to us, they only want to get the pharmaceutical coverage. We require that they be enrolled and that they have a medical evaluation, because we are not a drugstore, we are a medical system. We are concerned about continuity of care from primary care to geriatric care. So we just are not dispensing pharmaceuticals.

Mr. BUYER. Very good.

Secretary PRINCIPI. But my pharmacy budget has grown from $750 million to $2.5 billion and another $600 million to administer that program, so I am at $3.1 billion just to buy and administer a pharmacy program. It is a real struggle.

Mr. BUYER. Thank you. Ms. Carson.

Ms. CARSON. Let me, first and foremost, Mr. Secretary, reinforce, reiterate my respect and pride for the veterans having you as their leadership. I am not all that political, I think that the President did a yeoman's job in putting you in your position as Secretary of the Department of Veterans Affairs because you have a clue in terms of what these veterans face out here in this country. It is like blaming a mother for not giving her children the proper nutrition when you have taken all of her money away from her to make that possibility occur. I am not blaming you for the large cadre of homeless veterans in this country, because Congress sat up there—and I am not throwing a rock at Steve Buyer publicly——

(Laughter.)

Ms. CARSON (continuing). I really am not. But it is a matter of priorities, how we spend the money, the resources that we have for the human beings in this country.

Here in Indianapolis, we had one of the greatest—at the Roudebush Medical Center, one of the greatest in-house drug treatment programs that was known anywhere in this country. Budgetary restrains cut it back, we robbed Peter to pay Paul. A lot of those drug-infected veterans are now in prison somewhere. It is a hell of a lot cheaper to fix that problem at a VA Medical Center on an inpatient situation than it is to pay the humongous cost for housing veterans in prisons around this country. (Applause.)

And I think Congress—I am a part of it and I am going to stay a part of it so I can keep raising hell at forums like this—but Congress has got its priorities screwed up. We talk about the land of the free, we go in first thing in the morning and have prayer, pledge allegiance to the flag and rip off the veterans of this country. That is wrong and Congress needs to clean up its act and the veterans need to make Congress clean up its act. It is not your fault. (Applause.)

I admire the fact that you take issue because of your academic background and because of your expertise and because of your military background—you know the real deal.

You need to look at Marion dedicating a 100-bed facility at taxpayer expense and here you are closing down the beds one right after another. And that just does not make sense to me. The veterans need in-house medical attention. Marion is state-of-the-art. (Applause.)

You had a big dedication ceremony up there, saluted the flag and then started closing down the beds. And that was a whole bunch of money, Mr. Secretary, trust me.

Thank you, I yield back the balance of my time, Mr. Chairman. (Laughter.)

Mr. BUYER. Earlier, Mr. Chairman, you mentioned the three different stove pipes within the VA. From my standpoint, with 9 years on the Veterans' Affairs Committee, as I have looked at this, there is a cultural divide at times in the systems within the VA in trying to get them to talk to each other and communicate with each other. So when you talked about your information technology task force, can you elaborate a little bit more about the direction of the task force and where this is headed and at what time do you think you will have a conclusion and will you come back and explain that to the committee?

Secretary PRINCIPI. We had a task force of senior leadership across the entire department, who worked very, very diligently. I am very proud of them—they worked on weekends, it was not take some time off during the week, they started on Thursday night and worked to midnight, all day Friday, Friday night, Saturday and broke up on Sunday for close to 3 months, devoting that time. And they developed a plan, an enterprise architecture plan. The plan is basically the foundation for the three administrations to work together in the coordination and the development of our information technology and our telephone communication systems. And that report will be on my desk within days. They are very, very close to the final report. And that will be the framework that will be the architecture which will drive our investment strategy in systems and what we need and how all the different systems can talk to one another electronically.

We brought on a new Chief Information Officer. I come from the Navy, so I tend to bring on a lot of Navy people, but John Gauss headed up the Navy's information technology program and he is a wonderfully dedicated, intelligent person who is going to be in charge of our investment program in the future. So I am very excited about some of the changes and the new spirit of working together that I see in the VA, because communication is terribly important.

We do not need to have separate eligibility systems, we do not need to have lots of different separate systems. We do not need to spend a lot of money investing in this system and having another administration investing in a very similar type of system. That procurement should be together. And we should do the same thing with DOD. As the two health care systems, the DOD health care system and VA health care system move closer together to collaborate and partner, our information technology systems are moving further apart. We need to link those two systems so that a service member—so from the time a young man or woman enters the military entrance processing station, the recruiter's office, when they are 17 or 18 years old, every piece of information that is gathered about that individual is electronically stored so that throughout his or her military career and their years as a veteran, it should all be integrated so that we can make timely benefit and medical decisions. They should not have to scale high walls or go around walls, all of that information should be transmitted instantaneously to VA.

Today, as I indicated, it takes 90 days if we are fortunate to get a military or medical record out of the Records Center in St. Louis to the VA Regional Office here in Indianapolis or any one of the 58. Again, Federal Express can get any package anywhere in the world unequivocally overnight. DOD and VA, 3 months. I think we need to do better. And I think we can do better and it is a people issue.

Mr. BUYER. is your task force addressing the issue on privacy also?

Secretary PRINCIPI. Yes, absolutely.

Mr. BUYER. All right.

Secretary PRINCIPI. We are entrusted with information, we just brought on a cyber security director who is working with the task

group to address all of the security/privacy concerns, information that has been given to us by veterans.

Mr. BUYER. When you discuss the integration of DOD with the VA—and it is an issue that I have a passion about from when I served on the Armed Services Committee.

Secretary PRINCIPI. Right.

Mr. BUYER. Can you tell me how it is proceeding with our other systems—health care, procurement, and acquisition?

Secretary PRINCIPI. Well, I too am passionate about it because again, I think it is a money issue. I think there is a lot of wasted inefficiency, dollars that could be expended. We talked about the fact we cannot treat as many people as we want, we talked about the homeless beds.

Mr. BUYER. Can you give the committee an example of what you think are some ways?

Secretary PRINCIPI. I think we should consolidate, I believe we should consolidate VA, Department of Defense procurement systems for medical supplies, equipment and pharmaceuticals. We procure—just take pharmaceuticals, we procure pharmaceuticals for VA, Indian Health Service, Public Health Service and Bureau of Prisons. We are a model in procurement of pharmaceuticals because we have large volume contracts, we have a national formulary. I am very proud—you should be very proud of VA's pharmaceutical program and procurement program.

I believe by combining the $2.5 billion procurement program of VA with the DOD $2 billion procurement for pharmaceuticals, I believe we can command discounts even greater than we currently receive. And with standardization of medical equipment and supplies, I believe can again achieve greater savings. I think we have just begun to scratch the surface in what we can do.

Quite honestly, I believe there is too much decentralization in the procurement arena. If we have problems with our national acquisition center, then we need to address those, but I think there is more we can do there. So I think that is one example of where the two sides can come together.

Mr. BUYER. Mr. Secretary, we thank you for your testimony and for your appearance today. I know you are going to stay here this afternoon and dedicate the homeless center with Ms. Julia Carson and we appreciate your dedication to America's veterans.

Secretary PRINCIPI. Thank you very, very much, Mr. Chairman. (Applause.)

Mr. BUYER. The committee now recognizes the Honorable Richard Griffin, the Inspector General of the VA. Mr. Griffin, your written testimony has been submitted and will be in the record and I will give you 5 minutes for oral testimony.

STATEMENT OF HON. RICHARD GRIFFIN, INSPECTOR GENERAL, DEPARTMENT OF VETERANS AFFAIRS accompanied by ALANSON SCHWEITZER, ASSISTANT INSPECTOR GENERAL FOR HEALTHCARE INSPECTIONS, DEPARTMENT OF VETERANS AFFAIRS and WILLIAM DEPROSPERO, DIRECTOR, CHICAGO OPERATIONS DIVISION, OFFICE OF THE INSPECTOR GENERAL, DEPARTMENT OF VETERANS AFFAIRS

Mr. GRIFFIN. Thank you, Mr. Chairman.

Mr. Chairman and Congresswoman Carson, I am pleased to be here today to discuss the results of our combined assessment program review of the Department of Veterans Affairs Richard L. Roudebush VA Medical Center, Indianapolis, IN.

Our review at the medical center covered operations for the fiscal years 1999 to 2000. In performing this review, we inspected the structural and environmental conditions of the physical plant, interviewed medical center managers, employees and patients and reviewed pertinent administrative, financial and clinical records. The CAP team consisted of auditors, investigators and health care inspectors who examined 22 health care activities and 20 administrative activities.

The team concluded that administrative and clinical activities were generally operating satisfactorily. The medical center had adopted innovative treatment programs that provided significant benefits for veterans' wellbeing. For example, the staff fully implemented the primary care model supported by a patient response center to manage patients' problems over the telephone, eliminating any unnecessary outpatient visits.

Rehabilitation employees consistently evaluated their patients' progress using functional independence measures, which improved and personalized the treatment planning process and reduced rehabilitation clinic waiting times for appointments from 21 to 14 days.

Pathology and laboratory medicine had sound controls to ensure highly accurate tissue diagnoses and rapid communication of critical laboratory values to treating physicians ensuring effective treatment for serious illness.

Non-laboratory ancillary testing devices such as glucometers produced consistently accurate results attributable to the ancillary testing coordinator's intensive surveillance and monitoring of their use by nursing personnel.

While we concluded that clinical and administrative activities generally were operating satisfactorily, we made suggestions and recommendations in several areas that appeared vulnerable or were in need of improvement.

Our Roudebush VA Medical Center CAP report contains the details of our review and our conclusions, as well as 38 suggestions and four formal recommendations for improvement. The report also contains management's concurrence with our recommendations, including implementation plans that we believe are responsive and constructive. We recommended improvements in the following activities:

Administrative controls over human subject research projects
Surgical patient informed consents
Controlled substances inspections
Reconciliation of government purchase card activity
Training and education
Medical record documentation
Timekeeping for part time physicians
Equipment and medical supply inventories
And information technology security.

During the CAP review, my staff received inquiries from 23 patients and employees at the medical center. The individuals who

we talked to had concerns which we categorized into the following areas:

Patient safety or quality of care issues
Personnel and staffing-related issues
Administrative and resource management issues
Alleged fraud or other criminal activities.

We followed up on all of the allegations we received. In some cases, we referred the individuals to other appropriate offices such as the General Counsel or the Office of Resolution Management. In our opinion, there existed no particular pattern to these inquiries that would cause us to recommend any systemic remedial action to medical center management.

In addition, during the CAP visit, my investigative staff conducted several 60-minute fraud awareness briefings; 163 Roudebush VA Medical Center employees attended these presentations. Each session provided discussion of how fraud occurs, criminal cases prosecuted in the past in VA program areas and information to assist employees in preventing and reporting fraud.

Our complete 54-page CAP report on the Richard L. Roudebush VA Medical Center can be found on our website.

Mr. Chairman, this completes my opening statement. I will be glad to answer any questions you or the Ranking Member may have.

[The prepared statement of Mr. Griffin appears on p. 54.]

Mr. BUYER. Thank you. Would you please introduce who you have with you today?

Mr. GRIFFIN. With me today is Mr. Schweitzer, who is our Assistant Inspector General in charge of our Healthcare Inspection Unit and Bill DeProspero, who is the Director of our Chicago Region Audit Operations.

Mr. BUYER. Thank you.

When you gave the lists of conclusions and then recommendations, what did you see at this CAP review of Roudebush that you would call systemic within the VA system as you go around from region to region?

Mr. GRIFFIN. I would say that on a recurring basis we have seen problems with reconciliation of purchases using the government purchase card. There is a tremendous number of cards in the system and for many people, it is a collateral duty to be involved in the reconciliation of these purchases. As a result, we have seen on a recurring basis that reconciliation is not done timely and sometimes it is done without minimal review of the process.

We have seen recurring inventory control problems at other facilities concerning some of the more expensive drugs that are on the shelves at the medical centers.

We have seen problems in the destruction of drugs which have outlived their shelf life and which sometimes fall into the hands of people who sell them on the street or use them for other abusive purposes.

I think those are the principal recurring things that we are seeing at many of the facilities that we visit.

Mr. BUYER. From my perspective when I also talked with individuals from different regions, there is patient safety, there is informed consent and you hit the issue on safeguards—key control

custodians. Would you also add what I have added or would you say no, Steve, I disagree?

Mr. GRIFFIN. No, I would say in this particular facility, we did have a recommendation concerning informed consent. We have not seen that on a regular and recurring basis in our other CAP visits. It may be present at some other facilities but it is not one of the things that I would say that I read about in 80 percent of our reports.

Mr. BUYER. You were responsive to the question that I gave you. Maybe I should now ask the next question, what would be the top systemic problems around the country, if you could name those top three or four?

Mr. GRIFFIN. I think that from the standpoint of recurring——

Mr. BUYER. Recurring.

Mr. GRIFFIN (continuing). It sounds small to say credit card purchases, but it is over a billion dollars a year that is spent on purchases using credit cards. We have seen instances where as a result of lack of oversight, there are problems with split purchases to stay below the $2500 threshold, multiple purchases on the same day to stay below the threshold, and purchases of IT equipment when credit cards are not supposed to be used to purchase IT equipment. We had one criminal case that is ongoing in the Chicago region where a person gave his code number to a subordinate who automatically approved all the credit card purchases which he had made to include a couple hundred thousand dollars worth of computer equipment which was then sold on the street. So, due to the number of cards that are out there, the potential for problems and the volume of purchases being made, we are trying to monitor this activity.

Another item that I find troubling is the time and attendance for part time physicians. We have people in the VA that are responsible for doing time and attendance records and for putting hours into the payroll system, who have no knowledge as to whether or not that physician was there for those hours. So it is something that I think, across the board, needs to be tightened up. Some facilities are going to core hours, which require that for a fixed number of hours during each work week, the doctor would be required to be at the VA. With no requirements, you are vulnerable to people being more interested in their practice at the affiliate or in a private practice than they are with what they are supposed to be doing at the VA.

Mr. BUYER. In light of the recent research death of a patient at Johns Hopkins, how do your recommendations prevent such a tragedy? In your testimony, you referenced protection of human research projects at the Roudebush VA.

Mr. GRIFFIN. The protection that we were identifying in Roudebush was more one of privacy and one of being assured that the VHA policies concerning maintaining records of who is in a research program, what the protocols are, and that the privacy of all information is properly safeguarded.

Mr. BUYER. Thank you. Ms. Carson.

Ms. CARSON. Thank you very much.

Mr. Griffin, I recently made it clear what I thought about the outstanding value of a robust Office of the Inspector General when

I proposed an appropriations amendment to add staff positions to the Office of the Inspector General for the VA. And I realize that you cannot in your position respond to any of that. But, maybe creatively you can.

Tell me whether or not—the Oversight Committee works closely with your office in regards to our missions—and are you free to say, whether you believe that your work would be complemented substantially if you had additional IGs to cover more of the areas that you mentioned, on a more timely basis. You can answer that, can you not?

Mr. GRIFFIN. I can answer that, I would be happy to answer.

Ms. CARSON. Okay, I do not want to get you in a—I really do not want to, you know——

Mr. GRIFFIN. We absolutely would benefit from an increase in resources and I appreciate your support in that respect. I have to say that it is an unusual time when there is bipartisan support for an increase in IG resources. The fiscal year 2002 budget is going to conference soon, and we are hopeful that the House mark will prevail.

I am happy to report also that in our initial budget submission within the department, for 2003, we requested an increase of 55 FTE and the department has agreed to support that number. The reason we asked for this increase is we feel we need to have a proactive program. It does no good for us to be a totally reactive organization.

In my previous career, I was in the Secret Service and we used to say that there is little consolation in catching an assassin after the fact. Well, likewise, we want to be able to get out and do that part of the IG mission that we are chartered to do, that is, promote economy, efficiency and effectiveness, and to deter, not just identify, waste, fraud and abuse. I think in order to do that, you have to be out doing cyclical reviews, and not just at medical centers. We are fine-tuning the protocol for cyclical reviews of regional offices.

Tied to the requests that we have made and which we have discussed with staff members on the Hill, we are trying to get our cyclical review of medical centers and regional offices down to a 3-year cycle. We think that is a more reasonable time period than the current cycle of 6 years. Six years is much too long.

While doing these reviews, as we identify best practices, we publish those best practices. If we are in a facility in Chicago and we see that they have a problem with inventory control of drugs or some other area and we have just been to Indianapolis and we found that they had a model system there, we tell that medical center director in Chicago to contact the director in Indianapolis and let him share with you the excellent system that they have in place there. We cannot do that with our staffing as it is now. But with more staffing, we can shrink the cycle time, identify best practices, identify systemic issues as the Chairman suggested, and get that information to the Under Secretary at VHA, and also at VBA once we are fully engaged in the regional office combined assessment program.

Ms. CARSON. Do you know what the offset of those 50 additional staff would be. Under the budgetary scenario, you have to take

away—rob Peter to pay Paul. So do you know what the offset would be within the VA budget?

Mr. GRIFFIN. Fifty people would be slightly less than $5 million.

Ms. CARSON. Okay, do you know where the $5 million is coming from?

Mr. GRIFFIN. I am sorry, could you repeat the question?

Ms. CARSON. You have to have an offset. If we give you $5 million for IGs, then we have to take that away from something. That is called a balanced budget. (Laughter.)

That is what they call it.

Mr. BUYER. You are learning very well.

Ms. CARSON. So do you know what the offset would be to balance the budget? Do you take it out of benefits, out of what?

Mr. GRIFFIN. That would be a decision made at a higher level than mine.

Ms. CARSON. I would not answer that either. Thank you.

Mr. GRIFFIN. I am happy to say though that we have a 20-to-1 return on investment for the dollars that we have been given in our audit area and in our contract review area.

Ms. CARSON. I tried to tell the House that when I offered the amendment, that you would more than pay for yourself. It was like hitting a power ball. But they beat me down on the floor, so I am glad they sneaked it in the process. That is great. Thank you.

Mr. BUYER. Thank you very much for your CAP review of Roudebush, it is very helpful to the medical director and to the teams. And I appreciate your dedication. Thank you for your testimony here today.

Mr. GRIFFIN. Thank you, Mr. Chairman. (Applause.)

Mr. BUYER. If the next panel would please come forward. The next panel consists of Mr. Paul Curtice, the Veteran Service Officer, Morgan County Veterans' Office; Mr. Randy Fairchild, Veteran Service Officer of the Tippecanoe County Veterans's Office; Mr. William D. Jackson, Director of the Indiana State Department of Veterans Affairs; Mr. Jay Kendall, Veteran Service Officer from Miami County Veterans' Office and Mr. John Michalski, Commander of the American Legion, State of Indiana.

Gentlemen, your written testimony has been submitted and will be entered into the record and I have read your written testimony—I have read all of the testimony of everyone.

We are under the 5-minute rule of the committee and Mr. Curtice, if we could begin with you, we welcome you to the subcommittee and in my opening, as I stated, we have not received—in the 9 years that I have been on the committee, we have never received the testimony from the Veteran Service Offices that are located in the courthouses of this country, all those county courthouses. And what I have learned in representing the 20 counties I have in northern Indiana is the Secretary of the VA is correct, you are on the front lines, you see a lot of those veterans, many of whom do not have access, maybe they are looking for transportation or looking for help on filing a claim, they are looking for help in getting their records. And we are interested in your perspective of the VA, because sometimes in DC when we are working with those systems, we can get lost in the high weeds. So I want to

make sure that we are not, and we welcome your testimony here today.

Mr. Curtice, I yield to you and you have 5 minutes.

STATEMENTS OF PAUL CURTICE, VETERAN SERVICE OFFICER, MORGAN COUNTY VETERANS' OFFICE; RANDY FAIRCHILD, VETERAN SERVICE OFFICER, TIPPECANOE COUNTY VETERANS' OFFICE; WILLIAM D. JACKSON, DIRECTOR, INDIANA STATE DEPARTMENT OF VETERANS AFFAIRS; JAY KENDALL, VETERAN SERVICE OFFICER, MIAMI COUNTY VETERANS' OFFICE and JOHN MICHALSKI, COMMANDER, THE AMERICAN LEGION OF INDIANA

STATEMENT OF PAUL CURTICE

Mr. CURTICE. Thank you. First of all, I would like to clarify that I also am a Department Service Officer for the Veterans of Foreign Wars.

Mr. Chairman and members of the subcommittee, on behalf of the VFW Department of Indiana, I would like to thank you for the opportunity to express our views on the current state of Veterans' Affairs health care system in Indiana. I would also like to thank you for holding the hearings in Indiana where you can witness first hand the obstacles that confront your veteran constituents when dealing with the VA.

The VA health care problems that you hear about on Capitol Hill, such as waiting times, access, continuity of care, transportation, et cetera are not much different from those occurring in the VA health care system in Indiana.

As the VFW's Department Service Officer in Indiana, my first concern is continuity of care. Recently, the VA released a plan for the Northern Indiana Health Care System that proposed closing the nursing home in Fort Wayne and moving the patients to the Marion facility, reducing the inpatient acute medicine beds at the Marion facility and reducing the inpatient psychiatry census by 25 percent.

The consolidation of the Fort Wayne and Marion VAMCs may make sound fiscal sense, but it poses some real concerns to the continuity of care received by Indiana veteran. The success of their implementation relies on their ability to make a seamless transition. For example, I will assume for the VA to achieve its goal of reducing the inpatient psychiatry census by 25 percent, they will discharge as many as needed and at the same time, not admit new patients. I ask you, is that serving the veterans from the state of Indiana?

In order for VA to fulfill its responsibility and provide a continuum of care, that patient must not be discharged until access to the same services; i.e., counseling, education, et cetera, are available at an outpatient clinic near the veteran's new residence.

As for the consolidation of the nursing homes, we ask that this subcommittee and Congress ensure that VA complies with the Veterans Millennium Health Care and Benefits Act under Public Law 106–117 as it pertains to capacity for long-term care. In addition, no veteran currently residing in long-term care should be discharged to a non-VA facility. It is also important to note that the

distance between Fort Wayne and Marion is roughly 55 miles and that extra distance will cause a burden on the veteran and their family as far as visitation.

Indiana veterans also face long waiting times for specialty exams at all of our VAMCs. In fact, a veteran that we represent was recently told he could not be seen until February for an asthma condition.

The VA's focus must be timely access to quality health care and we appreciate the efforts of this subcommittee to ensure that that is the case.

This concludes my testimony and I will be available for any questions you may have.

Mr. BUYER. Thank you, Mr. Curtice. Mr. Fairchild.

[The prepared statement of Mr. Curtice appears on p. 58.]

STATEMENT OF RANDALL FAIRCHILD

Mr. FAIRCHILD. Mr. Chairman and members of the subcommittee, my name is Randy Fairchild. I retired from the U.S. Army in 1995 after serving 22 years. For the last 6 years I have served as the Tippecanoe County Veterans Service Officer. Tippecanoe County is the home of Purdue University, we have approximately 12,000 veterans residing there. We have the largest American Legion Post in the state, the 50th largest VFW Post in the Nation and our Tippecanoe Veterans' Council currently has 17 military service organizations in our membership. Tippecanoe County is also the home of the Indiana Veterans' Home that is superbly managed by Colonel (Retired) Robert Hawkins.

The Tippecanoe County Veterans Service Office is manned by Jackie Helvie and myself. We assist veterans and their families like many other veterans service offices across the Nation. We assist with VA compensation and pension claims, home loans, education, burial benefits and state veteran benefits. Our office coordinates transportation for veterans to both the Danville, Illinois Veterans' Medical Center and the Indianapolis Roudebush Veterans Medical Center by using the Disabled American Veterans van.

Four years ago, I was able to convince the Lafayette JOURNAL & COURIER to allow me to publish a biweekly article informing veterans of their VA benefits. This information reaches approximately 28,000 veterans in the seven county area. This article is a great tool in providing our veterans with information concerning their VA benefits.

I have been asked to appear today to provide you with information concerning the quality of care and management issues at the Roudebush VAMC and on the management and delivery of benefits by the VA regional office. Working at the grassroots of the VA system, Jackie and I are probably the first ones that a veteran complaints to concerning any VA problem, be it medical health care or VA claims processing. My testimony today will not be in the style of "he said, she said", but in trying to help you understand how the 80-year old World War II veteran to our youngest veteran sees the VA. I would like to begin with the VA medical care.

First of all, the 10–10EZ form, that is the enrollment form. This form is not easy enough. From the colored chart on the front page to the financial disclosure on the back, this form is insurmountable

for many of our older veterans. This form is in many cases, the first contact a veteran may have had in years with the VA.

Secondly, the Veterans Universal Access Identification Card. Veterans in northwest Indiana are confused by the need to re-enroll with the VA if or when they decide to transfer from receiving medical care at Roudebush to the West Lafayette Community Out-Based Clinic. Their comments range from "the VA already has the information" to "the card says universal". When the VA is constantly requesting financial information from our veterans, this fosters a feeling of mistrust among them. The universal ID card needs to become a better tool for the VA to assist veterans. Mr. Gobel presented the Danville VA Medical Center with this card in February 1996 and very little improvement has been made since that time.

Appointments. The vast majority of veterans are extremely frustrated by the length of time that it takes to get an appointment in the specialty clinics. For example, my nurse practitioner at the West Lafayette CBOC referred me to orthopedics at Danville on April 5, 2001 and my appointment was schedule for August 24, 2001. Why is it so difficult for the VA to fill these positions? Could there be a time limit set so if the veteran cannot be seen in a timely manner, they could be seen by a local doctor so that they can receive the care that is needed?

The Danville VAMC currently has over 900 veterans who are scheduled for their initial evaluations, over 650 applications received have not been scheduled as of yet. The wait for a new veteran to be seen in some of these CBOCs is over 6 months. The West Lafayette CBOC is currently not accepting new patients at this time.

Another concern in this area is the constant rescheduling of appointments. Our office normally has three to four veterans a week come in and ask for our help in contacting the appropriate VA medical center to see when their next appointment is scheduled. Many veterans receive a card or a letter showing the change and then at other times will get a call from the medical center. After a few of these, the veteran becomes confused on when exactly they are scheduled to go.

Medical subvention and co-managed healthcare. By far the greatest challenge facing county veterans service officers and others who assist our veterans is educating them why they have to pay the VA in the first place. Many say I have served and that should be the end of the story.

The current system has veterans receiving health care from both their private doctors, subsidized by Medicare, and the VA doctor paid by the government, so that they can receive their prescriptions at a reduced rate. The veterans cannot understand why the VA will not honor their private doctor's prescription. So in essence, veterans are having a Medicare deducted monthly from their Social Security and then if they are found to be over the VA income threshold, they're charged a $50.80 co-pay to be seen again for the same injury or illness that their private doctor just saw them for. With the VA depending on this co-pay and collections from third party payees, many veterans feel that they are having appointments made just for the VA to fatten their coffers. Many veterans are told

by their private doctor that they do not need to be seen for a year, while the VA doctor wants to see him in 6 months or earlier.

In the co-managed health care program, veterans are quickly wedged between the VA doctor and their private doctor of who is right or wrong. The veteran wants to continue to see the doctor that they have seen for many years, while at the same time be able to continue to receive their medicines through the VA. With Category 7 veterans not being assured VA health care from one year to the next, this puts them in a tight spot.

Mr. BUYER. Mr. Fairchild, I know——

Mr. FAIRCHILD. I will conclude my testimony now.

Mr. BUYER (continuing). You are reading from the prepared testimony that has been submitted in the record. What would be helpful though is if you would move to your recommendations.

Mr. FAIRCHILD. As has been mentioned earlier, Congressman Buyer, the Medical Subvention would greatly help the VA with financially being able to continue to see the Category 7s. It is real hard for a veteran to understand why $50 is coming out of his Social Security for Medicare and then when he goes to see the VA, he is charged $50.80 again for the same illness. We are being redundant in having the veteran have to see two separate doctors.

Mr. BUYER. Could you conclude with your recommendations on the education piece, please?

Mr. FAIRCHILD. On the education, my article in the paper, I try to write it where they can understand, where I can understand what is going on and just everyone needs to understand that the VA is on a budget. Even if you are a World War II veteran, you served in combat, somebody still has to pay. So I think just education on everybody's part of why they have to pay.

Mr. BUYER. Thank you, Mr. Fairchild, for your testimony.

Mr. FAIRCHILD. Thank you, sir.

Mr. BUYER. Next, we will hear from Mr. William D. Jackson, who is the Director of the Indiana State Department of Veterans Affairs. We thank you, sir, for being here and for your leadership.

[The prepared statement of Mr. Fairchild appears on p. 60.]

STATEMENT OF WILLIAM D. JACKSON

Mr. JACKSON. Thank you, Mr. Chairman, and members of the committee. I do appreciate the opportunity to be here and give testimony today. You do have a copy of my written testimony and I will give an abbreviated form of that.

Mr. BUYER. Thank you, sir.

Mr. JACKSON. To try and catch us up here if we can.

I do have a concern, as Director of Veterans' Affairs, with both—and have a vested interest in both of the areas that you have considered today in the VA Medical Center on West 10th Street as well as the regional office of the VA located here on Pennsylvania Avenue.

In conjunction with that, and you may or may not be aware of, nor may Secretary Principi, but our Lieutenant Governor, a former POW and former Navy pilot, was not aware of his benefits until we visited the VA Medical Center here in Indianapolis and we were having a conversation out there about benefits and what veterans are entitled to. He was not aware of it, when he found out some

of the benefits he was entitled to, he said, you know, I have been a mayor of a major city in Indiana for 9 years and Lieutenant Governor and if I do not know about those benefits, what about that poor person living out here in the hinterland, he obviously, or she, does not know about those benefits.

So he made a commitment to establish an outreach program in conjunction with our office, the regional office here in Indianapolis, the VA Medical Center at Roudebush, the Roudebush VA Medical Center, to try and ensure that we do communicate those benefits and get those out to every veteran within the state of Indiana. Thus far, we have sent out benefits brochures, which includes the federal benefits as well as state benefits. We have mailed those to approximately 70,000 veterans within the state.

In conjunction with that, the regional office and Roudebush have worked with us, as well as our county service officers at many of our training seminars, to get the word out within each county. And I do appreciate the fact that you invited the county service officers here today because these gentlemen and ladies throughout the state of Indiana, some 91 of them, work extremely hard in providing those services back to the benefits within the state and it is a group that I am very proud of and I work with each year on the training process.

Regarding complaints on quality of services from either facility, the most common one I receive is the length of time it takes for a veteran to get an appointment to see a doctor. The time span has been running approximately 6 months, which I personally feel and I agree with the committee is much too long for a veteran to have to wait to get to see a doctor.

I am also concerned about the resources for VISN 11. I understand that our region, based on the President's budget for fiscal year 2002, is projecting a deficit of $33 million. Obviously if this is correct, cuts will have to be made and this could affect the quality of services provided to our veteran population.

We have a major problem, I feel, not only within the VA system, but within the lines of communication between VISNs. Two CBOCs were established in Indiana. We have several CBOCs, but two new ones were established in Indiana, which did not—one of them was administered out of Dayton, OH and one out of Cincinnati, the Medical Center in Cincinnati. I was never notified, our staff was never notified, nor the regional office here was never notified it was established and neither was the medical center here ever notified. When I finally found out about them from the county service officers, by the way, that these new ones had been established, I called Dayton, called Cincinnati, and they said well, you are not in our VISN, so we had no reason to notify you. I said well, if that be the case, then why did you put them in our VISN. So there seems to be a continuing problem on communication, not only between the states and the federal government, but within the VA itself.

Mr. BUYER. Mr. Jackson, last time I checked, we do not have an immigration policy with Ohio. (Laughter.)

Mr. JACKSON. Thank you. I am not sure whether we do or not.

Mr. BUYER. I do not think so.

Mr. JACKSON. But it seems to be a problem. We would like to help promote those but if we do not know about them, it is very

difficult to promote them. So I bring that to the Secretary's attention while he is here today in the hopes that we can resolve that problem.

In summary, overall, our agency is very pleased with the management and quality of care being provided to veterans by both the VA Regional Office here in Indianapolis and the Roudebush VA Medical Center, with the exception of the areas that I mentioned above.

My staff and I look forward to facing the challenges of not only the federal VA system, but those we encounter in state government as well. We will address them as a partner in a cooperative manner, just as we have for the past 4½ years.

Again, I appreciate being given the opportunity to be here today and provide you with some information from a state perspective.

Mr. BUYER. Thank you, Mr. Jackson.

Next we will hear testimony from Mr. Jay Kendall, who is a veteran service officer from Miami County Veteran's Office. And if you want to know why you are here, it is that Miami County, when we went to that realignment of Grissom Air Force Base from an active base to a reserve base over the last decade, you have had a great experience. So we would like you to share some of that with us.

[The prepared statement of Mr. Jackson appears on p. 64.]

STATEMENT OF JAY A. KENDALL

Mr. KENDALL. Thank you, Mr. Chairman. I am Jay Kendall, I am a Veterans Service Officer. I was born and raised in the Grissom area and I did my 20 years in the Air Force and returned to the Grissom area.

I am now at the pointy end of this sphere, what I call talking to the veterans. I talk to the widows, to the veterans. I can claim this since I am a Hoosier, we have got very proud and very stubborn Hoosiers and we have a lot of people that do not know the benefits, as Mr. Jackson said. But what has happened is we have got a good thing and the outpatient clinic thing that we are working on now, the system that we have, the word is out and we have a lot of people coming in to see me. I go through them all the time, I brief them up and I send them out.

The example I have—and I am going to cut a little bit to the chase here—is that less than a year ago, I could send a person to the Marion VA and I could tell them that could walk in with a 214 in their hand and they could see a doctor that same day. Now, in order to get him to see a doctor, it is 3 or 4 months. So the process has gone out, it is probably up to 6 months here in Indianapolis, is what I am hearing. So it has expanded. I do not have the answers for this, but that is the problem that I see.

Some of the problems that I do see, that I hear about from the veterans, is the formulary drug list. There is a national list, but not all VISNs and not all medical centers follow the list. So I can send one veteran to Indianapolis or to another VISN, Battle Creek, wherever. They can get drugs up there, but when they come back, they cannot get drugs. So I would ask that you enforce the national formulary list.

Second—and this has only happened recently—is a prioritization and coordination between the medical facilities. I have seen that

the coordination is getting better but now there is more of a "me first" attitude. And my example is, you know, in coordination, lost files. I had a veteran, Mr. Brewer, he went down to Indianapolis from Marion and they lost his file. As a result—and I cannot say this for sure—but he lost his lung because of the time it took to figure out that he had a spot on his lung. So now he is living with one lung. He blames the VA on the time it took in order for him to figure this out. I ask that the VA not prioritize all the local—you know, all the state of Indiana counts on Indianapolis for specialized care and we cannot have a "me first" attitude with Indianapolis.

One of the answers I do have is that the CBOCs are a great thing. I went to one in Muncie, I have been to the one in South Bend, to Lafayette. They are flooding in to these places. I have spoke with one of the doctors who controls these CBOCs and he says that he could put 40 clinics in Indiana if he was granted the money and the time, he could do that inside 45 days for each clinic. He put Muncie on line in 45 days. But it is the VA that is taking their time in picking out where these places are. Grissom area would be a perfect place for one. So I just wanted to let you know that I think that this could be expanded and that the CBOCs should be increased as soon as possible.

Some of the problems that I do have is the older vets, talking to them about the long-term comprehensive care. They do not understand why they cannot get help from the VA. Or talking to a widow—this one gets me a lot—talking to a widow that she would have to be below the poverty level in order to qualify for widow's pension. That just does not work. A Vietnam vet about Agent Orange or a Desert Storm vet about Gulf War Syndrome. Those are hard answers for me to—I have to dance for them and I do not like dancing.

Tell a vet that it takes so long to get any records from St. Louis. If it takes the VA 3 months to get records from St. Louis, it takes us 3 years. I have had a guy going 7 years trying to get records from St. Louis. They are lost, they cannot find them, they are in the VA, they are back in St. Louis. You know, he said he was going to camp out in St. Louis.

And finally, being retired, I am trying to explain to the disabled and military retirees how they are not receiving concurrent pay as the other federal employees do. That is a hard one for me.

Overall, I think that the VA is doing a fine job. The current attitude "more with less" is impossible to provide health care with less. They have to be doing a good job today. Congress must realize the importance of the contribution the VA is making and continue to increase funding for the VA. In the future, I do not want to have to tell a Category 7 guy, after I have told him all the benefits that he gets from the VA, that he can no longer go there and get benefits.

That concludes my statement, sir.

Mr. BUYER. Thank you, Mr. Kendall.

Next, we will hear testimony from the Commander of the American Legion of Indiana, John Michalski.

[The prepared statement of Mr. Kendall appears on p. 66.]

STATEMENT OF JOHN J. MICHALSKI

Mr. MICHALSKI. Thank you, Mr. Chairman, members of the subcommittee; thank you for the opportunity to present the views of the American Legion Department of Indiana on the quality of care and management issues at the Indianapolis VA Medical Center and on claims processing issues at the Indianapolis Regional Office.

Our organization recognizes and appreciates the efforts of this committee, the VA and Congress to substantially improve quality and access to medical care of veterans over the past several years. Since enactment of Public Law 104–262, the Veterans Health Care Eligibility Reform Act of 1996, veterans in all seven eligibility categories have been entitled to a full and comprehensive package of health care services from VA medical centers.

The Indianapolis VA Medical Center is a prime example of excellent delivery of services by the VA. It provides a full range of health care services and does so in a friendly and courteous manner. We rarely receive complaints concerning the quality of its services.

However, we do have one significant local concern. A few years ago, the American Legion Department of Indiana chose not to oppose VA's plan to close the Cold Springs Road VA facility here in Indianapolis. That facility provided long-term nursing home care and care for mental health patients. The VA had entered into an agreement with the State of Indiana, which provided for the State to either lease or purchase the Cold Springs Road facility, and consequently to use the proceeds of the sale or lease to expand services, particularly nursing home care services at the remaining VA medical facility here in Indianapolis.

This apparent win-win situation would benefit the VA by relieving it of the burden of maintaining two medical facilities and nursing home and mental health patients by providing direct access to physical medical care without having to endure a transfer between hospitals.

Nevertheless, several years now have passed and there has been no expansion of services for nursing home patients and mental health patients at the remaining VA medical facility here. We know that the original agreement, which the Indiana American Legion supported in good faith, netted the Indianapolis VA Medical Center approximately $3 million. That money has not been used and has since increased to about $3.3 million.

We also understand that this area's Veterans' Integrated Service Network Number 11 is facing a deficit in excess of $30 million. It is our concern that the VISN may attempt to reduce its budget deficit by attaching the $3.3 million meant for local veterans. Those veterans have already given up an entire VA medical facility for unfulfilled promises.

Beyond the initial $3 million, the VA medical care system no doubt has saved millions more in recurring expenses that they have not had to meet. VA should apply the original proceeds meeting its commitment to local veterans and expand nursing home and mental health services at the remaining VA facility here.

Despite this concern, we do acknowledge that one huge improvement in the system has been the expansion of the outpatient system. However, the inconsistency from one outpatient clinic to an-

other is very apparent. We were told once a patient was in the system, any outpatient clinic would be accessible and this is not true.

In Secretary Principi's speech to the American Legion National Convention in San Antonio, he mentioned the organization of teams to clear up old claims. This is commendable and we are glad to see what is being done. However, what is being done to see that the age-old problem of claims is being rectified? Is this all going to occur again, or not?

One might think that the Veterans Benefits Administration can do nothing right. Complaints are everywhere.

1) Some say the VBA provides too little information about a decision—then it provides too much.

2) Some say that the VA should make a decision quickly without waiting for so much evidence, while others complain that the VA made a decision on their case without assisting enough in helping them find evidence, which the VA is now mandated by law to do.

3) Some say that the VA employees lack proper training; others say VA can get nothing done because VA employees are always in training.

4) Some complain that VA letters contain too little information; others say VA letters are too confusing because they contain too much information.

Obviously both sides of these issues cannot be right. But it does clearly demonstrate that the claims process is poorly understood by most veterans.

Locally, we understand the VA Regional Office has hired more VBA employees. This is long past due. When the VA Regional Office decides to work on improving one area of claims processing, such as new claims, it falls behind in working on other areas of its responsibilities, such as the processing of appealed cases.

We only hope that VA will properly train its new employees, see them as long-term investment in America's veteran and avoid the temptation to discharge more experienced VBA employees with buyouts.

The American Legion Department of Indiana encourages the VA to continue work on this area.

Ladies and gentlemen, this concludes my testimony.

[The prepared statement of Mr. Michalski appears on p. 68.]

Mr. BUYER. Thank you very much.

Our next panel that will be testifying will be the Director of VISN 11, so hopefully you have taken some good notes because they have raised some very good points. So we are anxious to hear your testimony.

I think, Mr. Fairchild and Mr. Jackson brought up two very good points, not only about your budgetary, and I want you to make sure you address that, and this issue on the national formulary and different VISNs or localities applying—having different standards on drugs. I just want to make sure you have a mental preparation.

Mr. Curtice and Mr. Fairchild and Mr. Kendall, I compliment you on your testimonies—not that I don't compliment you, Mr. Jackson or the American Legion——

(Laughter.)

Mr. BUYER (continuing). I know that you have staff also to help you prepare. They did this on their own—not that you did not, sir,

but sitting in that county courthouse on that Selectric typewriter—no, you did excellent testimony and very thoughtful.

The one issue that Mr. Fairchild—I am almost taken aback here, gentlemen, the opportunity you have had, do you notice that the Secretary has been sitting here listening to your testimony? I just had to lean over and tell Ms. Carson, I do not ever remember one of the President's cabinet secretaries ever sitting through an entire hearing. (Applause.)

That speaks highly of you, or you do not have anything to do. (Laughter.)

No, I was just teasing.

Ms. CARSON. And you did not go to sleep, I was watching you.

Mr. BUYER. The issue on the outpatient clinic, if you could help me here. When the Secretary testified and we talked about when Congress did the eligibility reform and we opened the doors and we sort of transformed the VA from that system that cared for the service-connected disabled, and it is a different entity today, and the question is Congress, in our intent, did we really go too far, if in fact we are now beginning to cause overloads on appointments to those of whom were part of the core competency of the VA. So I am interested in your opinions here in light of the Secretary's testimony and this statement. Mr. Fairchild.

Mr. FAIRCHILD. Sir, I would just like to comment, in West Lafayette, our CBOC has been open 2½ years and we have almost 3000 veterans signed up now. My wife is an LPN there, so I hear more about the CBOCs than I hear about my own daughter, of how many people who want in there daily, who come in with a 10–10EZ,. As Jay commented, it is a great system, it is up to Congress and our government of how much money we want to put in to take care of the bigger numbers of veterans. Which they are going to get their care somewhere, either through the Medicare, state clinic or through the VA. It is great, they love the workers out there. I think we need to just plow on with this. As Jay said, the World War II veterans who are in their 80s, to be able to drive two miles to a CBOC sure beats driving all the way to Indianapolis.

Thank you, sir.

Mr. BUYER. Thank you. Ms Carson.

Ms. CARSON. I would like to defer my questions.

Mr. BUYER. All right. Gentlemen, thank you very much for your testimony. (Applause.)

Our next panel will consist of Ms. Linda Belton, Director of the Veterans Integrated Service Network 11. Accompanying Ms. Belton is Dr. Michael W. Murphy, Director of the VA Northern Indiana Health Care System, Department of Veterans Affairs; Mr. Robert Sabin, Director of the Roudebush VA Medical Center, Department of Veterans Affairs. Also testifying will be Mr. Jeffrey M. Alger, Director of the VA Regional Office in Indianapolis, Department of Veterans Affairs. Next in testimony will be Ms. Teri James, a registered nurse, President of AFGE Local 609. Accompanying her is Mr. Frederick G. Bitner, President, AFGE Local 610 and Mr. William Overbey, President of AFGE Local 1020. Ms. Belton.

STATEMENTS OF LINDA BELTON, DIRECTOR, VETERANS INTEGRATED SERVICE NETWORK 11, DEPARTMENT OF VETERANS AFFAIRS accompanied by DR. MICHAEL W. MURPHY, DIRECTOR, VA NORTHERN INDIANA HEALTH CARE SYSTEM, DEPARTMENT OF VETERANS AFFAIRS and ROBERT H. SABIN, DIRECTOR, RICHARD L. ROUDEBUSH VA MEDICAL CENTER, DEPARTMENT OF VETERANS AFFAIRS; JEFFREY M. ALGER, DIRECTOR, VA REGIONAL OFFICE, INDIANAPOLIS, DEPARTMENT OF VETERANS AFFAIRS; TERI JAMES, PRESIDENT, AFGE LOCAL 609 accompanied by FREDERICK G. BITNER, PRESIDENT AFGE LOCAL 610 and WILLIAM OVERBEY, PRESIDENT, AFGE LOCAL 1020

STATEMENT OF LINDA BELTON

Ms. BELTON. Thank you.

Mr. BUYER. I have read your testimony and we will be under the 5-minute rule.

Ms. BELTON. Mr. Chairman and members of the committee, thank you for having me here today to discuss VISN 11; Indianapolis and Northern Indiana Health Care System.

VISN 11 provides services across Michigan, northwest Ohio, Indiana and central Illinois.

Mr. BUYER. We can barely hear you.

Ms. BELTON. Nearly 1.5 million veterans reside within the network's service area and through May of 2001, we enrolled more than 206,000 veterans.

Over the past 2 years, Congress has increased VHA's medical budget by approximately $3.5 billion. At the same time, eligibility reform and VA's basic benefits package have allowed many veterans to enroll and obtain services. Budgets and other performance goals are driving all networks, including VISN 11, to find ways to provide care more efficiently.

All network facilities participate in nationally certified external accreditation processes, including Joint Commission, CARF and CAP. Our most recent Joint Commission survey was in the fall of 2000 with scores ranging from 86 to 93. Indianapolis and Northern Indiana have also been accredited by CARF.

Network facilities participated in the IHI project to decrease clinic waits and delays and while some improvements have been achieved, you have heard today that increased demands, space limitations, critical staff vacancies, resource constraints, continue to present challenges in this area.

In 1998, VISN 11 partnered with VA's National Center for Patient Safety in piloting a systems approach to patient and staff safety. And since then, we have been provided with executive training for network leadership, employee education on sentinel events and root cause analysis. Staff from Indiana facilities have participated in 14 educational sessions on preventing and managing disruptive behavior.

VHA has undertaken an aggressive performance measurement system. One performance measure monitored in this network is pharmacy waiting times, with a goal of 30 minutes or less for a prescription to be filled. Last year, Indianapolis averaged 31 minutes, Marion 30 minutes and Fort Wayne 24 minutes.

You asked about budget. Networks receive appropriated funds through the VERA model. Between 1996 and 2001, our operating allocations through VERA increased by 12.2 percent. However, VISN 11 has not been able to keep pace with inflation and national mandates. The network has responded by shifting care to less costly outpatient settings, reducing unnecessary duplications, standardizing supplies, expanding the use of blanket purchase agreements and many other actions.

VISN 11's fiscal year 2001 budget allocation was $721 million. Budget distribution to facilities was based on fiscal year 2000 actual expenditures plus about 5 percent. Collections from MCCF totaled $26.4 million in 2000 and we project to collect about $34 million this year.

VISN 11 currently has 23 community based outpatient clinics. This brings 85 or more percent of our veterans to within 30 miles of a VA primary care site. Five of these are located in Indiana at South Bend, Muncie, Bloomington, Lafayette and Terre Haute and the Lafayette CBOC is collocated at the Indiana State Veterans Home.

Ms. CARSON. Ms. Belton, it is very hard to hear you.

Ms. BELTON. Am really sorry.

The Lafayette clinic is collocated at the State Veterans Home. Is that better? Thanks.

While workload plans for the CBOCs range from 1000 to 1500 patients per year, almost all have met or exceeded their capacity. In fiscal year 2001, the network has also budgeted a million dollars to expand mental health to community based outpatient clinics.

In response to the Mil bill, VISN 11 plans to increase VA nursing home census by 82 at the end of 2003. In Indianapolis, an enhanced use project for construction of a private sector nursing home on VA grounds is also proceeding. Network long-term care needs are met through a combination of VA, contract nursing homes, state veterans home and home and community based services.

Over the next year, VISN 11 expects to take part in CARES, the Capital Asset Realignment for Enhanced Services. And that may result in structure and mission changes across the network.

VISN 11 staff works closely with VBA regional offices in Detroit and Indianapolis. Our network comp and pen processing times are consistently below the national average of 35 days. And 99 percent are found adequate for rating purposes.

VA Medical Center in Indianapolis and Northern Indiana are really integral parts of VISN 11's health care delivery system. We will continue to face challenges in managing within our appropriated budget, improving the quality of care, improving the perception of the veteran of that quality of care and in effectively communicating these changes with many groups—labor partners, education affiliates, veterans groups and others. I am really confident that the staff and leadership of the Indiana VA facilities are up to that challenge.

Mr. BUYER. Thank you, Ms. Belton. Mr. Alger.

[The prepared statement of Ms. Belton appears on p. 73.]

STATEMENT OF JEFFREY M. ALGER

Mr. ALGER. Mr. Chairman and members of the subcommittee, I have been invited to attend today's hearing to discuss the current situation and future challenges of the compensation and pension program at the Indianapolis VA Regional Office. The managers and line employees at the Indianapolis VA Regional Office are dedicated to providing world class service to Indiana's veterans and their dependents. I would like to orally provide a brief summary of my written testimony.

The Regional Office is charged with providing service to the entire state of Indiana. There are approximately 573,000 veterans living in this state. We are currently paying benefits in active claims to about 52,000 veterans and dependents living in Indiana. Of this number, approximately 38,000 are claimants receiving benefits for service-connected disabilities. We are paying out over $26.5 million per month with an annual benefits outlay of approximately $318 million.

Our service center makes over 30,000 decisions on claims per year, conducts over 14,500 personal interviews per year and handles about 104,000 telephone inquiries per year.

During the past year, we have established over 31,600 claims, either new or reopened. Of these, 720 were in regards to a change in law regarding claims for presumptive service connection of diabetes due to herbicide exposure for Vietnam veterans and 900 were due to new legislation regarding VA's duty to assist veterans in the development of their claims. Our current pending workload is at 6900 or so, it changes weekly.

The Regional Office has been adequately funded for the past 2 years in support of our employment, travel and other needs. We have an annual budget of over $8.7 million. In addition to that, in fiscal year 2001, we utilized $1.3 million to provide contract counseling services in the state through our Vocational Rehabilitation and Employment Service program.

I want to emphasize that we are proud of our balanced scorecard accomplishments for this year. The balanced scorecard is a method by which VBA measures outcomes in five broad categories—speed, accuracy, unit cost, customer satisfaction and employee development and satisfaction. Within each broad category, there are specific functions or actions used to measure actual station performance.

In rating related end products completed, we are at 155.2 days as compared to the national average of 176.5 days. Our rating related pending workload, this is our inventory, is at 133.2 days, in comparison to the national average of 172.3 days. In our non-rating related end products completed, our average number of days to complete is less than a month, at 27.2 days, compared to the national average of 50.9 days. And our pending workload is at 74.6 days compared to the national average of 114.3 days. Our appeals resolution time continues to be one of the best in the Nation at 462 days compared to the national average of 597.4 days.

Continued training and focus on our error trends is helping us to gradually improve our quality scores. We anticipate that we will meet or exceed all of our accuracy goals for this fiscal year. In telephone activities, we are among the best in the Nation in our ratio

of abandoned calls and blocked calls. Indianapolis is one of the pilot sites for establishment of what is called a virtual information center for answering telephone calls. This is an initiative whereby we utilize all stations in Service Delivery Network (SDN) 2 to answer telephone calls incoming from anywhere in the SDN. For example, if a Hoosier veteran calls the Indianapolis Regional Office on our toll-free line and all our lines are busy, the veterans call will be automatically transferred to an available line anywhere in the SDN. This transfer is automatic, our data information system allows any service representative in the SDN to access claim information for other stations in the SDN. Therefore, Veteran Service Representatives (VSRs) are able to answer veterans' inquiries in a majority of cases.

I would like to say that 19 percent of our current workforce will be eligible for retirement in the next 3 years. We were authorized an increase in our FTE ceiling during the past year from 145 to 161. We have completed all hiring, to include three new rating specialists. All newly hired employees are in the midst of their centralized training program and are fully utilizing available modules of our computer assisted training program called the Training and Performance Support System.

In answer to a recent inquiry, I can tell you that over half of our recent hires are veterans.

We have hired an additional decision review officer to bring our total to three. All decision review officers work closely with the service officers to ensure that veterans are taking full advantage of having their cases reviewed under the de novo review authority outlined in the regulations creating this program.

This completes my formal presentation to the subcommittee and I will be happy to answer any questions. Thank you.

Mr. BUYER. Thank you, Mr. Alger.

Ms. Teri James, you are now recognized for 5 minutes.

[The prepared statement of Mr. Alger appears on p. 92.]

STATEMENT OF TERI JAMES

Ms. JAMES. Chairman Buyer and Ranking Member Carson, my name is Teri L. James, I am President of Local 609 of the American Federation of Government Employees. Local 609 represents professional health care workers at the Richard L. Roudebush VA Medical Center in Indianapolis, IN. Nationwide, the AFGE represents 135,000 VA employees.

I have worked as a registered nurse at the Indianapolis VA Medical Center for 10 years. Prior to that I was an RN at the Marion, Indiana facility for 13 years. Both my parents were RNs at the Marion facility and retired from there, and my grandfather and uncle were nursing assistants at the Marion facility and retired from there.

The lack of adequate staffing at the Indianapolis VA Medical Center is a great concern for the health care providers that the AFGE represents. These health care providers are the first and foremost patients' advocates. They are concerned about how veterans suffer and patient safety is jeopardized due to lack of adequate staffing.

From September of 1995 to September of 2000, nationwide, the VA cut its registered nurses by 10 percent, its licensed practical nurses by 13 percent and nursing assistants by 30 percent. This has meant a loss of 1 in 6 direct patient caregivers.

The staffing crisis impacts the quality of care the veterans receive and threatens the patient safety. When there are not enough RNs and support staff to care for the patients, staff are more likely to make medical errors. Even when medical errors are avoided, patients will still suffer. Medical records, medications, basic care and critical medical interventions are delayed, forgotten or mixed up because the staff is spread too thin.

The perils of understaffing are evident at our medical intensive care unit, or MICU. This unit is for veterans who need a high level of constant care and have severe medical conditions. The unit is supposed to operate with nine RNs on all shifts plus one staff member whose sole responsibility is to watch the cardiac monitors. A safe staff-to-patient ratio is one RN per one or two MICU patients. Rarely does the VA management meet this staffing.

Recently MICU had seven RNs for 24 patients, or a ratio of one RN to 3.4 patients. Of these 24 patients, eight had medical conditions rated at the most extreme acuity level. These eight patients were all on respiratory ventilators. Safe staff dictates one RN for each of these patients. This is to ensure that each patient would have a dedicated nurse to monitor his or her breathing and respond immediately to a ventilator alarm. The failure to respond immediately to a ventilator patient in distress could mean the patient's death. VA management's failure to adequate staff MICU and other units places patient safety at risk.

The VA is also vulnerable to the growing shortage of social workers and medical technologists and pharmacists. We are also having difficulty recruiting and retaining physical therapists and other key therapy staff who are indispensable to veterans' care.

AFGE Local 609 is concerned that the VA management is not responding adequately to this crisis in staffing. Even though we have a significant problem in retaining and hiring staff, our facilities management has stated they are actively avoiding a recruitment and retention bonus.

Promotions are also key in retaining your nursing staff. Our facility management has failed to recognize the work of experienced nurses by denying them pay promotions from a Nurse I to II and from a II to III, In our facility, promotions to a Nurse Level III are infrequent.

Competitive pay is also key in keeping nurses on staff, improving morale and becoming the employer of choice. Recently, our facility gave Nurse Level I RNs a 3 percent pay increase, their Nurse Level II RNS a 2 percent pay increase and then the Nurse Level IIIs had no increase at all.

By law, RNs receive a premium for working on weekends. This premium is not for overtime but for a regular shift. Pharmacists, physical therapists, respiratory therapists and licensed practical nurses are guaranteed only Sunday premium pay as they are the hybrid employees. Saturday premium pay is at the option of the medical director for these hybrid employees. Our facility's manage-

ment has used its authority to deny many of these key employees their Saturday premium pay.

For Title 5 employees like medical technologists and nursing assistants, the law prohibits them from being paid premium pay for working a regular shift on Saturday. For these employees, the law only provides them Sunday premium pay.

Chairman Buyer and Representative Carson, I urge you to support changing the law to ensure that all VA employees who work on Saturday receive the Saturday premium pay.

Moreover, the way that VA management treats its workforce ultimately rebounds to DVA's genuine desire and capability to honor veterans with compassionate and high quality care.

Chairman Buyer and Representative Carson, I thank you for holding this oversight. Thank you. (Applause.)

[The prepared statement of Ms. James appears on p. 100.]

Mr. BUYER. From a management standpoint, Mr. Secretary, I am glad you are still sitting here. Maybe if Congress stepped in and said pay that premium pay, maybe you would have some different management decisions here on how much these directors are stressing the staff. Maybe they would be more motivated—I am just giving you some thoughts. Maybe there is greater motivation there to make sure they get those hires. I do not know—you know. Well, I will retain my thoughts. (Applause.)

Ms. CARSON. Could I ask one quick question because I know time is vital here.

Mr. BUYER. Sure.

Ms. CARSON. This stress factor, when you have workers working long hours in the kind of jobs you have in terms of seeing all the sickness, how does that play into the quality of the medical care that the patients receive?

Ms. JAMES. I think the staff becomes so overtired and overwhelmed that the care that the veterans deserve is slower in coming, if that is making any sense. They deserve a rapid response, they deserve as much care as you can give them in your eight or 12 hour shift that you are there. If there is not enough staffing, it is not adequate, then you are spread where you are only allowed to spend so many minutes per veteran. You are not able to talk with them, discuss their concerns and spend time getting more care given to them.

Ms. CARSON. Thank you, ma'am.

Mr. BUYER. Mr. Alger, in your testimony on appeals, boy, I know you gave some numbers and I could feel the pride that you gave in your numbers, but to me, 462 does not represent pride with regard to an appeal time line. What is your goal, to bring that down to what? What do you think is a more acceptable number, what do you think the community standard ought to be on an appeal?

Mr. ALGER. I would say that first off, that is a difficult question. I think if I look at the national target for appeals resolution this past year, the national target was 650 days. That is—you are right, that is unconscionable. You have to, I think, also realize that the 462 days of timeliness at the Indianapolis Regional Office was due to a special team, we have a special appeals team that works only on appeals. They do take pride in their work, they work the complex cases. To say what would be the final goal, my final goal actu-

ally would be to process the claims right the first time so that veterans never have to appeal the decision.

Mr. BUYER. Oh, good answer.

Mr. ALGER. So I do not have a number for you, I am sorry.

Mr. BUYER. All right, I was curious.

To Mr. Bitner and Mr. Overbey, I appreciate your appearing here today, I have read your testimony and to Mr. Overbey, in your testimony, I am going to sort of plagiarize, if I may—I will not plagiarize, I will give you credit in the question.

The question I have here to Ms. Belton and to Dr. Murphy, in Mr. Overbey's testimony, he said that on June 1 of 2001, this subcommittee held a hearing in Marion, Indiana and that you testified about how inadequate staffing was placing care at risk. Since that hearing, the VA received supplemental funding—you know, this VISN and your health hospitals, Dr. Murphy, received supplemental funding for fiscal year 2000.

Mr. Overbey feels that unfortunately this money was not used to improving staffing levels. The staffing numbers at Marion and Fort Wayne have remained basically the same, the status quo he feels is unacceptable.

Now I recall that hearing and Chairman Stump came to Indiana to address some of those concerns. I recall you putting monies in but I also recall that the plus up was to be around $10 million and that did not happen. So I agree now with Secretary Principi's earlier remarks, there is an accountability function. So would you please explain to me why the committee took the time to give a microscopic look at Marion and we believed that something was going to happen and it has not happened. So would you please now respond?

Dr. MURPHY. We did receive some additional ramp up funding and we have been recruiting diligently since that time. As a matter of fact, our current FTEE is up 15 from where it was at the time of the hearing. The areas where we are most challenged to recruit are the areas where everyone is challenged in recruiting. It is obtaining physicians, it is obtaining RNs and in particular LPNs. Our RN cadre is up a net of six during that time frame and our LPN cadre has remained unchanged, we lose one, we gain one, we gain one, we lose one. They are hard folks to recruit and they are hard folks to retain. Some of that is the contractual conditions under which we work them. Others are salary and competitive offers from other employers.

I will say that while our total employment is up by only 15, our employment in the patient care areas, people who have hands on the patients, is up 23. Our clinical administration and MCCR, which is a very important function to us, is up by 2.5 and our facilities positions in engineering and housekeeping are down by about 11, so we have redirected resources to support clinical positions and we have recruited with a full steam, no stops effort. It is just that the folks, as you heard in a hearing in July last year with the other hospitals in northern Indiana, are scarce and difficult to recruit. Respiratory therapists are difficult to recruit too, pharmacists are nigh onto impossible to recruit and we have them on a very significant recruiting and retention package just to get and to hold onto them.

Mr. BUYER. Mr. Overbey, are you familiar with the specifics that Dr. Murphy just testified about?

Mr. OVERBEY. The numbers, I am not exactly sure where all the numbers are at that he is talking about. I know since the hearing, we have closed another unit or two, of our inpatient units and I know one of those units—we closed a unit and the purpose for closing that unit, this was back in the winter—the purpose for closing that unit was solely lack of staffing, we did not have enough staff, the staff was spread too thin to staff all the units that we had, so we had to close one. Since that time, we have not reopened any units, we are still understaffed.

Our facility—what causes a lot of our staffing problem is the status for the psychiatric inpatients. A lot of times it is a one-on-one observation thing, one staff per one patient and that takes a lot of staff on a 25-patient unit.

I do not know how many of those numbers are divided—I do not know the numbers between Fort Wayne and Marion, how many of those staff went to Fort Wayne and how many went to Marion. I do not know—Dr. Murphy said they were in clinical patient care areas, I do not know if that is nursing staff. I think you said 15 RNs or six RNs and 15 nursing assistants, something like that.

Dr. MURPHY. Fifteen total.

Mr. OVERBEY. Fifteen total.

Dr. MURPHY. Our RN count is up six, the LPN count is a zero balance.

Mr. OVERBEY. And how much of that is Fort Wayne, how much is Marion, do you know?

Mr. BUYER. Let me ask this, at the hearing, I recall that there was—and this was post-hearing—that there was a renewal between labor and management. Give me a test of the temperature, has it improved?

Mr. OVERBEY. Well, actually, yeah, I think——

Mr. BUYER. Are you communicating and talking?

Mr. OVERBEY. I think we have done some good things. I mean you have got to give Northern Indiana credit, I mean in 1996, we treated what, 12,000 patients and last year, we treated over 22,000 I think it was.

Dr. MURPHY. Last year it was 18,000 this year it will be over 24,000 by the time the fiscal year ends.

Mr. OVERBEY. We have had a substantial increase in workload and I was reading the testimony earlier and looking at all the accomplishments that some people have listed in there of how we have done so much more with so much less. At the same time, we are patting ourselves on the back because we are increasing the workload so much, we have decreased our staff by like 20 percent or something like that.

And my question is when does somebody stop patting themselves on the back for decreasing staff, decreasing costs and treating more and say it is not enough, we cannot do it any more. We have to have more to do more. (Applause.)

Mr. BUYER. Last question I have. Ms. Belton, there was testimony by Mr. Jackson on the previous panel about a shortfall for the VISN. Could you please address that question that he had?

Ms. BELTON. Yes, I can. Can you hear me okay?

We are projecting—obviously we do not have our fiscal 2002 allocation at this point in time, so we are speculating, looking at rates of inflation and pay increases, looking at increases in workload, which have been substantial, that we are looking at in the area of $25–30 million shortfall for next year. That certainly causes us some big concerns. We are looking at a number of areas and have worked this past year to try and prepare for that. I do not know if you are interested in talking about that, but I can certainly verify that we anticipate a significant shortfall.

Mr. BUYER. That is what I need, was your verification. Ms. Carson.

Ms. CARSON. Thank you very much, Mr. Chairman, I am going to have to depart shortly. The Secretary is going to dedicate the Carson Home to homeless veterans, but I am going to submit written questions to all the panel members and would trust that you would favor me with a response.

Mr. BUYER. No objection.

Ms. CARSON. I do very quickly want to ask, Marion is closing psychiatric beds and all 16 medical beds? Whose decision was it and if that is happening, was there some independent review commission in place that came back with that recommendation?

Dr. MURPHY. There is no plan of record to close beds, there is no plan document in preparation. Our planning is to focus on returning patients to the community as appropriate. The Secretary said we should take care of patients in the most appropriate setting on an individual basis. For some that will be in a VA institution, for others that will be some type of community living arrangement. Today, we have 93 patients living in the community, being supervised by a staff of approximately five under the Mental Health Intensive Case Management, acronym known as MHICM. Those 93 patients, if they were in the hospital, would fill close to four wards and would take 100 staff to support them. We are taking care of them in an appropriate way in the community, meeting their needs with a staff of five.

We have been working for the past year with a consultant group out of Boston which focuses on psychiatric rehabilitation and returning patients to the community. They have focused on developing staff skills, staff skills and assessing patient readiness for rehab to focus on going to the community. What we are doing is fully consistent with their efforts and their experience. They have worked with a large variety of state and federal and some VA facilities along the same line, of returning patients to the community.

I think we should not keep veterans in psychiatric institutions unless there is no other viable, appropriate setting for them. We can provide those viable, appropriate settings in the community with staff training, staff support and preparation for patients. And I will give you one example. We recently moved one of the patients from Marion psychiatry to Indianapolis in Indy's Psychiatric Residential Rehab Program. This patient had been institutionalized for a number of years. We put him into the program in Indianapolis, which focuses on return to community, development of community skills. As a result, that patient is now living at home with his mother and in fact is an IT, incentive therapy, employee at Indianapolis. I think that is a tremendous mark of success for what we

are all about. We are not about institutionalizing people inappropriately, we are about——

Ms. CARSON. Mr. Murphy, I do not want to interrupt you because I know you have your views on that and I am not being disrespectful. My concern was the dedication of a 100-bed facility in Marion at a humongous cost and in less than a few months, you were beginning to deinstitutionalize it. That to me is money wasted. (Applause.)

I believe in the community rehabilitation process. You know, I agree that we need to be servicing people in the community when we can, but it also sounds like you have staffing level problems and you were trying to reduce the number of patients in the hospital so that that problem would not exist.

Dr. MURPHY. That absolutely——

Ms. CARSON. I am not being disrespectful to you and what you are saying, but I still do not know who made the decision to build the facility and who made the decision to deinstitutionalize it within that short period of time—I do not know who did that.

Dr. MURPHY. The effort to move patients to the community is not a staffing issue, it is an appropriate environment of care issue.

Ms. CARSON. My question is who made the decision to build the facility in the first place and who made the decision to deinstitutionalize—that is all I am asking, Mr. Murphy, I am not trying to be disrespectful.

Dr. MURPHY. All I can give you is my understanding of secondhand information. When Cold Springs Road was in the process of being closed, I believe Senator Lugar raised the question who is going to provide care for Indiana's veterans in psychiatry and if my information is correct, Congressman Buyer stepped forward and said we have a project to build a replacement structure at Marion, which will accommodate that need. That was 5, 6, 8, maybe 9 years ago now or getting close to it.

Mr. BUYER. Not that long.

Dr. MURPHY. Eight years ago, in that time frame. The building was built and I think right now we are not finding an appropriate clientele being referred to fully utilize that building as it was designed. We are moving patients through our acute admissions unit at a very nice pace with an average length of stay of about 12.5 days before they step down to an intermediate level of psychiatry care. I think that we are moving patients, we are treating them properly and we are finding the appropriate setting for them to go to.

Ms. CARSON. I appreciate and respect that very much, Mr. Murphy.

From where I sit, and I realize you are strictly in that arena, but from my perspective, I see the prison population escalating and a lot of them have mental problems, veterans in prison across this country. And it would just seem to be more humane to have them in a setting of that kind to care for them rather than have them on the street going to prison.

Thank you very much, I respect your position and hope you will respect mine.

Dr. MURPHY. Thank you. I do.

Mr. BUYER. The only last question that I have that I did not get to ask is last year Congress enacted legislation, the VA Personnel Act, that gives VISN directors the ability to retain and recruit health care professionals and we gave VISN directors leeway to offer health care professionals an increase in pay. I would like to know whether or not you are utilizing, accessing, this legislation.

Mr. Sabin, Dr. Murphy?

Dr. MURPHY. We have sought and approved sign-on bonuses for our most difficulty—one of our most difficult to recruit for group of employees, namely pharmacists. It is fairly routine in our physician hiring to enter folks based on their experience and skills they bring us at above the entry level. And we have been doing that, again in a difficult to recruit employee category.

Mr. BUYER. Mr. Sabin.

Mr. SABIN. Yes, we are using those tools at the Indianapolis VA Medical Center, Mr. Chairman. We have recently adjusted the pharmacy pay schedule with Central Office approval. We have also utilized special salary rates with our imaging personnel, and provided recruitment and retention bonuses to nuclear medicine technicians and CT technicians. In addition, we are using the locality pay authority to good effect for our nurse staffing. The Nurse I's have had an increase this year of 7 percent through August, with another pay review due in January.

Mr. BUYER. Thank you.

The subcommittee will be submitting some written questions for various witnesses who have testified today. So when you get those, please promptly respond.

I would like to thank everyone who attended here today. This hearing is now concluded.

[Whereupon, at 12:37 p.m., the subcommittee was adjourned.]

APPENDIX

Department of Veterans Affairs **Memorandum**

Date: August 1, 2001

From: Associate Director (001)
Chief of Staff (11)

Subj: Program Changes – Implementation Plan

To: Director (00)

1. The following is an implementation plan for the following programmatic changes:
   - Consolidate all nursing home patients to the Marion Campus by 10/1/01.
   - Consolidate all acute medicine inpatients to the Fort Wayne Campus by 10/1/01.
   - Decrease inpatient psychiatry census by 25 patients by 10/1/01.

2. Patients from the Nursing Home Care Unit will be either discharged as a course of their treatment; transferred to another facility either in the community or at Marion Campus. Nursing Home staff from the 5th floor at Fort Wayne will be redeployed to fill current approved vacancies in the following areas:
   - Ambulatory/Primary Care
   - Acute medicine
   - HBPC

   Employees in the positions listed below will be reassigned.
   - Registered Nurses
   - LPNs
   - Nursing Assistants
   - Recreation Therapist
   - Social Worker
   - Ward Clerk

   Other employees will have changes to their duties, including:
   - Pharmacy – Pharmacists and Technicians
   - Respiratory Therapy
   - Occupational Therapy
   - Physical Therapy
   - Speech Therapist
   - Physician
   - Nurse Practitioner
   - Laboratory
   - Imaging
   - Dental
   - Nutrition & Food – Dietitian and Food Service Workers
   - SPD
   - EMS

- Chaplain
- Performance Improvement
- Voluntary Service

Minor changes in duties will be required for the following employees:

- Psychologists
- Podiatrist
- Audiologist
- Engineering
- IRM
- Safety
- Health Information/MBO
- DSS
- Fiscal
- Personnel
- MCCR
- Mental Health
- Optometry

Although not employees, volunteers' duties and opportunities will be dramatically altered. Voluntary Service is currently identifying new opportunities for volunteers in Primary Care and Outpatient Care to fill this void.

A small number of beds (5 to 8) on the 4th floor will be designated as sub-acute. The total number of beds on the 4th floor will not exceed 30. These beds will be utilized for patients that require extended care beyond their acute stay. Rehabilitation patients will be referred to the Marion campus. Length of stay for these patients will not generally exceed 30 days. Accreditation and management of these beds will be under Primary Care/Medicine.

Space on the 5th floor will be used to house administrative functions from other floors in the hospital. Space that is vacated on other floors will be assigned as additional outpatient clinic space for Mental Health Programs and Primary Care. Equipment, including beds will be redeployed or excessed depending upon condition and other needs.

3. The change for acute medicine at the Marion Campus will alter the not only the admission and treatment of acute medicine patients but also 23 hour admissions and respite care.

   Employees in the following positions will be reassigned to other vacant positions in extended care, mental health and primary care.

   - Registered nurses
   - LPNs
   - Nursing Assistants
   - Ward Clerk
   - Social Workers

Employees in the following positions will have **changes** in their duties.

- Pharmacy – Pharmacists and Technicians
- Respiratory Therapy
- Physician
- Nurse Practitioner
- Laboratory
- Imaging
- EMS
- Chaplain
- Performance Improvement

Minor changes in duties will be required for the following employees:

- Occupational Therapy
- Physical Therapy
- Speech Therapist
- Psychologists
- Audiologist
- Dental
- Nutrition & Food – Dietitian and Food Service Workers
- Voluntary Service
- Engineering
- SPD
- IRM
- Safety
- Health Information/MBO
- DSS
- Fiscal
- Personnel
- MCCR
- Mental Health
- Optometry

Effective September 15, 2001 we will cease admitting acute medical, Respite and 23-hour patients to 138 3C, at the Marion Campus. Patients requiring acute medical hospitalization will be admitted to another unit consistent with their clinical needs, transferred to Fort Wayne, transferred to Marion General Hospital or another community facility, or transferred to Indianapolis. Respite patients will be admitted to extended care beds at Marion, based upon their clinical needs. 23-hour admissions will be referred to Fort Wayne.

Equipment, including beds will be redeployed or excessed depending upon condition and other needs. Space will be reassigned to outpatient programs and support functions.

4. Decrease in inpatient psychiatry census will involve the three non-acute units and will eventually result in closing of one of the four wards in building 185. Treating

staff will determine each patient's suitability and readiness for discharge. As patients are discharged from non-acute units, the beds will be placed out-of-service until the necessary reductions are achieved. When inpatient census reaches 75 patients or less, unit 185 2C will be changed from an inpatient unit to outpatient mental health functions. The target date for achieving reducing inpatient psychiatry census to 75 patients is 10/1/01. Equipment, including beds will be redeployed or excessed depending upon condition and other needs.

Employees in the following positions will be reassigned to other vacancies in mental health or extended care.

- Registered nurses
- LPNs
- Nursing Assistants
- Ward Clerk
- Social Workers
- Psychologists

Employees in the following positions will have **changes** in their duties.

- Physician
- EMS

Minor changes in duties will be required for the following employees:

- Pharmacy – Pharmacists and Technicians
- Laboratory
- Recreation Therapy
- Occupational Therapy
- Physical Therapy
- Kinesiotherapy
- Nurse Practitioner/Physician Assistant
- Imaging
- Speech Therapist
- Respiratory Therapy
- Audiologist
- Dental
- Nutrition & Food – Dietitian and Food Service Workers
- Voluntary Service
- Engineering
- SPD
- IRM
- Safety
- Health Information/MBO
- DSS
- MCCR
- Optometry

5. These plans will be reviewed with both AFGE Local 1020 and 1384. Impact on working conditions and implementation will be negotiated as necessary. At this time

management is not proposing to use Reduction-in-force procedures to accomplish the reassignments.

6. Accomplishment of these changes will result in improved operating efficiencies and enhance our ability to provide treatment for more veterans with our available resources.

Robert H. Beller

V. N. Vitalpur, M.D.

STATEMENT OF

THE HONORABLE

ANTHONY J. PRINCIPI

SECRETARY

DEPARTMENT OF VETERANS AFFAIRS

BEFORE THE

SUBCOMMITTEE ON OVERSIGHT AND INVESTIGATIONS

COMMITTEE ON VETERANS' AFFAIRS

U.S. HOUSE OF REPRESENTATIVES

September 5, 2001

****

Mr. Chairman and Members of the Committee:

I welcome this opportunity to appear before the committee to discuss my goals for VA because the achievement of our national goals will have a direct effect on VA's services and benefits for Indiana's veterans.

Our goals, based on my five-part vision for VA, encompass health care, benefits, medical research, our national cemeteries, and VA's business practices. No one goal can be achieved in isolation – VA's future success requires an integrated plan of action.

VA is no longer the brick-and-mortar monolithic institution that it once was. And that's as it must be. Quality of care and management issues at Richard L. Roudebush VA Medical Center and across the landscape of the Northern Indiana Health Care System require an integrated and flexible plan of action – an action plan that can address multiple conditions simultaneously across the entire VA network.

This is the 21st Century. Veterans have become accustomed to computers that multi-task, to delivery services that send packages around the world in hours, and to getting answers to questions at the press of a key.

Indiana's 573,000 veterans have earned the right to access a 21st Century-capable network of care and services from VA – and they should not have to accept anything less than timely, compassionate, and effective delivery of such care and services.

In the past few years, VA has dramatically transformed the veterans health care system. Our Veterans Health Administration moved from an inpatient model of care, characterized by a limited number of large facilities often far from a veteran's home, to an outpatient model providing veterans with care at over 800 new sites.

Today, we provide better quality care than ever before. With 27,000 fewer employees, VA provided care to about 930,000 more veterans across the country in 2000 than we did in 1993.

I am committed to seeing VA become the nation's recognized leader in providing high-quality health care to a clearly-defined segment of the American people. In particular, I want us to lead in the areas where we have a unique role to play in America's health care: spinal cord injuries, blind rehabilitation, severe psychological conditions, geriatric care, and care for veterans who do not otherwise have access to good healthcare options.

The Northern Indiana Health Care System – comprising the Marion and Ft. Wayne Medical Centers, and its Community Based Outpatient Clinics in South Bend and Muncie – when coupled with the Roudebush Medical Center and its

two clinics in Bloomington and Terre Haute, and our Regional office in Indianapolis, responds daily to the broadest possible range of medical and benefits issues for Indiana's veterans.

Each component of the system contributes a depth of expertise that makes the whole system responsive to the varied needs of Indiana's veterans. Whether it's neuropsychiatric referral at Marion, surgical services at Ft. Wayne, or medical research in Indianapolis, VA has a resource to meet every challenge.
Dr. Michael Murphy can present a more detailed picture of the Northern Indiana Health Care System, but I want to stress up front that VA works best when we work together – and here in Indiana, we are working as a team on behalf of all Indiana's veterans.

The Roudebush Medical Center is an outstanding example of what VA is becoming – an unmatched nexus for treatment, rehabilitation, and research for America's veterans.

Robert Sabin, our Director of the Roudebush Medical Center, can fill in the details about the center's work, but let me say that from AIDS research to prosthetics services to homeless veteran programs to cardiac care, the Roudebush Medical Center places veterans at the very heart of care and respect.

The Roudebush Center has a long and proud history of taking care of Indiana's veterans: More than 38,000 veterans from 33 counties visit the Medical Center annually. In keeping with my vision of improving and raising VA's research profile, the Roudebush Medical Center is actively engaged in some of the most important research on AIDS, Alzheimer's Disease, Hepatitis, and cancer.

The Roudebush Medical Center also has been funded for a research project to

evaluate telemedicine applications for home care.

Other initiatives include working with the Institute for Healthcare Improvements (IHI) on projects to decrease waiting times in clinics and delays with veterans obtaining appointments; evaluating the patient advocacy program; working with the IHI to reduce adverse drug events; and bar coding for inpatient pharmacy.

VA medical facilities in Indiana are undertaking a number of quality and safety initiatives to continually improve quality.

The Computerized Patient Record System (CPRS) began in 1998 and is now used throughout the state's VA system. CPRS insures that a patient's primary doctor receives all data on that patient's care, regardless of source.

These new programs, and the improvements to come, will have a direct impact on my vision for VA to become the nation's recognized leader in disability compensation and disability evaluations. This is a core mission our department and we must do better. It is the foundation upon which the VA is built and the basis for our programs.

The quality of veterans' disability evaluations conducted at the Roudebush Medical Center, as well as improvements in the management of veterans' health records, will be reflected in the timeliness and quality of the delivery of health-related benefits and the adjudication of veteran's claims.

On that point, let me reaffirm my goal to reduce the enormous backlog of 650,000 claims that are currently pending before our department. We must have claims decisions made in ninety days, and done right the first time. We've done it

before, we will get there again. Jeffrey Alger, Director of our Regional office here in Indianapolis, will provide details about benefits services provided locally.

Last spring, I commissioned a Claims Processing Task Force, headed by Admiral Dan Cooper, to conduct a top to bottom review of our claims system. The Task Force will soon provide me with recommendations to speed our decisions by changing our organizational and administrative procedures.

I have not waited for the task force's report to take action. Since January 20th, VA has added more than 900 decision makers to help reduce the claims processing backlog, and we will add 60 more before the end of September. By the end of this fiscal year we will have hired an additional 1400 employees and trained them in proper claims processing procedures.

In response to the President's direction, I am forming a "Tiger Team" to take on the oldest claims filed by the oldest veterans. I never again want to report to the President, or to the Congress, that a veteran has died while his or her claim languished in a VA file drawer.

The Tiger Team will make decisions on claims filed by veterans over age 70 whose claims are now over a year old. If the claim is waiting for medical information, the Team will have my authority to cut through the red tape to get the necessary records or exams.

My vision for VA includes recognition of National Cemeteries as National Shrines. Health care at the Roudebush Medical Center can help Indiana's veterans achieve the best possible life. But when a veteran dies, he or she must be accorded the highest honor the Nation can bestow. How we care for our veterans in death says much about our nation's respect for their lives.

And finally, Mr. Chairman, let me address for a moment my fifth vision, that VA must use sound business principles to accomplish our mission. We must use the resources entrusted to us as efficiently and effectively as possible. All our VA Medical Centers, clinics, and outreach health facilities will benefit from improvements in the way we conduct our operations.

I have established an Acquisition Reform Task Force to make recommendations on much-needed reforms in our $5 billion procurement program for goods and services. These reforms will have an impact on all our services, and I would expect that the Roudebush Medical Center would be a beneficiary of improvements in VA's business practices.

Mr. Chairman, I assure the Committee that VA is making significant strides toward becoming the best health-care system in the world. VA Medical Centers like the Roudebush Medical Center are leading the way to that goal. We are committed to redeeming the debt we owe to Indiana's veterans -- and to all our Nation's veterans.

Mr. Chairman, that concludes my remarks.

STATEMENT OF

RICHARD J. GRIFFIN
INSPECTOR GENERAL
DEPARTMENT OF VETERANS AFFAIRS

BEFORE
THE UNITED STATES HOUSE OF REPRESENTATIVES
COMMITTEE ON VETERANS' AFFAIRS

SUBCOMMITTEE ON OVERSIGHT AND INVESTIGATIONS

Mr. Chairman and Members of the subcommittee, I am pleased to be here today to discuss the results of our Combined Assessment Program review of the Department of Veterans Affairs (VA) Richard L. Roudebush VA Medical Center (VAMC), Indianapolis, Indiana. I will also summarize our hotline and investigative activities throughout the State of Indiana.

Combined Assessment Program Reviews

Combined Assessment Program (CAP) reviews are part of my Office's effort to visit VA facilities on a cyclic basis, and to ensure that safe, high quality health care and benefits are provided to our Nation's veterans. CAP reviews combine the knowledge and skills of my Office's auditors, investigators, and healthcare inspectors to provide collaborative assessments of VA field facilities. At VA health care facilities:

- Auditors' review selected financial and administrative activities to ensure that management controls are effective.
- Investigators conduct Fraud and Integrity Awareness Briefings to improve employee awareness of fraudulent activities that can occur in VA programs.
- Healthcare Inspectors evaluate how well the facility is accomplishing its mission of providing safe, high quality health care, and improving access to care, with high patient satisfaction.

In addition to this typical CAP review coverage, Office of Inspector General (OIG) staff may examine issues or allegations that have been referred to the OIG by employees, patients, members of Congress, or others.

Our review at the Indianapolis Medical Center covered operations for Fiscal Years 1999 to 2000. In performing this review we inspected the structural and environmental conditions of the physical plant; interviewed medical center

managers, employees, and patients; and reviewed pertinent administrative, financial, and clinical records. The CAP team consisted of auditors, investigators, and healthcare inspectors who examined 22 health care activities and 20 separate administrative activities.

The team concluded that administrative and clinical activities were generally operating satisfactorily. The medical center had adopted innovative treatment programs that provided significant benefits for veterans' well being. For example:

- Staff fully implemented the primary care model supported by a Patient Response Center to manage patients' problems over the telephone, eliminating any unnecessary outpatient visits.
- Rehabilitation employees consistently evaluated their patients' progress using Functional Independence Measures which improved and personalized the treatment planning process, and reduced Rehabilitation Clinic waiting times for appointments from 21 to 14 days.
- Pathology and Laboratory Medicine Service had sound controls to ensure highly accurate tissue diagnoses, and rapid communication of critical laboratory values to treating physicians ensuring effective treatment for serious illnesses.
- Non-laboratory ancillary testing devices such as glucometers produced consistently accurate results attributable to the Ancillary Testing Coordinator's intensive surveillance and monitoring of their use by nursing personnel.

Although we concluded that clinical and administrative activities generally were operating satisfactorily, we made suggestions and recommendations in several areas that appeared vulnerable or were in need of improvement.

Our Roudebush VA Medical Center CAP report contains the details of our review and our conclusions, as well as 38 suggestions and 4 formal recommendations for improvement. The report also contains management's concurrence with our recommendations, including implementation plans that we believe are responsive and constructive. We recommended improvements in the following activities:

- Administrative controls over human subject research projects
- Surgical patient informed consents
- Controlled substances inspections
- Government purchase card program
- Administrative oversight and review
- Training and education
- Program development and Performance improvement
- Treatment environment, Infection control, and Safety
- Medical record documentation
- Timekeeping for part-time physicians

- Equipment and Medical supplies inventories
- Information technology security

During the CAP review, my staff received inquiries from 23 patients and employees at the Medical Center. Many of the individuals who we talked to had multiple concerns which we categorized into the following areas:

- patient safety or quality of care issues
- personnel and staffing-related issues
- administrative and resource mismanagement issues
- alleged fraud or other criminal activities
- miscellaneous issues

We followed-up on all of the allegations we received. In some cases, we referred the individuals to other appropriate offices such as the General Counsel or the Office of Resolution Management. In our opinion, there existed no particular pattern to these inquiries that would cause us to recommend any systemic remedial action to medical center management.

In addition, during the CAP visit my investigative staff conducted several 60-minute fraud awareness briefings. Approximately 163 Roudebush VA Medical Center employees attended these presentations. Each session provided discussions of how fraud occurs, criminal case examples, and information to assist employees in preventing and reporting fraud.

Our complete 54-page CAP report on the Richard L. Roudebush VA Medical Center can be found on our website at http://www.va.gov/oig/53/reports/2001-2reports.htm.

Hotline Activity

The OIG operates a hotline where veterans, employees, and members of the public can report crimes, fraud, waste, abuse, and mismanagement involving VA programs and operations by mail, e-mail, fax, or toll-free telephone number. Our annual contacts exceed 15,000 from which we open approximately 1,200 hotline cases for OIG or Departmental review of specific and serious allegations. Approximately one-third of the cases are substantiated. For the past 3 fiscal years, our Hotline has opened 15 cases involving VA facilities located within the State of Indiana. Summaries and pertinent excerpts of the cases have been provided to the committee. The cases included allegations involving quality of patient care, benefits fraud, mismanagement of resources, and employee misconduct. The allegations did not reveal any unusual trends or problems in Indiana VA facilities, and were representative of the types of allegations we receive nationwide.

Investigative Activity

We have conducted 26 criminal investigations in the State of Indiana during the last 2 years. The OIG Central Field Office conducts these investigations. The Special Agent in Charge of the office reports that he and his staff enjoy a good working relationship with VA officials in the state and issues or allegations of criminal conduct have been referred for investigation in a timely manner.
Eleven of our cases in Indiana are still under active investigation with several pending criminal prosecution. During the past year, the majority of our investigative work in Indiana has involved the Department's Compensation and Pension programs and several of these cases have been initiated based on referrals from VA officials working in the benefits delivery system. Our investigative work at the Richard L. Roudebush VA Medical Center includes instances of diversion of drugs from the VA facility. In each case, we received cooperation and assistance from VA management and we have worked closely with the VA Police at this facility to address matters of mutual concern.

Closing

Mr. Chairman, this completes my opening statement. I will be glad to answer any questions that you or Members of the Sub-Committee may have.

STATEMENT OF

PAUL D. CURTICE, DEPARTMENT OF INDIANA SERVICE OFFICER
VETERANS OF FOREIGN WARS OF THE UNITED STATES

BEFORE THE

SUBCOMMITTEE ON OVERSIGHT AND INVESTIGATIONS
COMMITTEE ON VETERANS AFFAIRS
U. S. HOUSE OF REPRESENTAIVES

WITH RESPECT TO

QUALITY OF HEALTH CARE AND MANAGEMENT ISSUES AT INDIANA
VETERANS AFFAIRS MEDICAL CENTERS

INDIANAPOLIS, IN SEPTEMBER 6, 2001

MR. CHAIRMAN AND MEMBERS OF THE SUBCOMMITTEE:

On behalf of the Veterans of Foreign Wars of the United States and the VFW Department of Indiana, I would like to thank you for the opportunity to express our views on the current state of the Veterans Affairs (VA) health care system in Indiana. I would also like to thank you for holding the hearing in Indiana where you can witness firsthand the obstacles that confront your veteran constituents when dealing with the VA.

The VA health care problems that you hear about on Capitol Hill such as waiting times, access, continuity of care, transportation, etc... are not much different from those occurring in the VA health care system in Indiana.

As the VFW's Department Service Officer for Indiana, my first concern is continuity of care. Recently, the VA released a plan for their Northern Indiana health care system that proposed closing the nursing home in Ft. Wayne and moving the patients to the Marion facility; reducing the inpatient acute medicine beds at the Marion facility; and reducing the inpatient psychiatry census by 25 percent.

The consolidation of the Ft. Wayne and Marion VAMC's may make sound fiscal sense, but it poses some real concerns to the continuity of care received by Indiana veterans. The success of their implementation relies on their ability to make a seamless transition. For example, I will assume that for the VA to achieve its goal of reducing the inpatient psychiatric census by 25 percent they will discharge as many as needed and not admit new patients. I ask is that serving the veteran?

In order for VA to fulfill its responsibility and provide a continuum of care that patient must not be discharged until access to the same services (counseling, medication, etc...) are available at an outpatient clinic near the veteran's new residence.

As for the consolidation of the nursing homes, we ask that this subcommittee and Congress ensure that VA complies with the Veterans Millennium Health Care and Benefits Act, PL 106-117, as it pertains to capacity for long term care. In addition, no veteran currently residing in long term care should be discharged to a non-VA facility. It is also important to note that the distance between Ft. Wayne and Marion is roughly 55 miles. This extra distance does place a burden on the veteran and his family.

Indiana veterans also face long waiting times for specialty exams at all VAMC's. In fact, a veteran that I represent was recently told that he could not be seen until February for his service connected asthma condition. This is an outrage that must be corrected.

The VA's focus must be timely access to quality health care and we appreciate the efforts of this subcommittee to ensure that that is the case.

This concludes my testimony and I am available for any questions this subcommittee may have.

Statement of

Mr. Randall Fairchild

Tippecanoe County

Veterans Service Officer

Before the

Committee of Veterans' Affairs

Subcommittee on Oversight and Investigations

U.S. House of Representatives

September 5th, 2001

Mr. Chairman and Members of the Subcommittee:

My name is Randy Fairchild. I retired from the United States Army in 1995 after serving 22 years. For the last six years I have served as the Tippecanoe County Veterans Service Officer. Tippecanoe County has approximately 12,000 veterans living there. We also have the largest American Legion Post in the State; the 50th largest VFW Post in the Nation and our Tippecanoe Veterans Council currently has 17 different military service organizations in our membership. Tippecanoe County is also the home of the Indiana Veterans Home that is superbly supervised by Col (Ret.) Robert Hawkins.

The Tippecanoe County Veterans Service Office is manned by Jackie Helvie (my assistant) and myself. We assist veterans much like all Veterans Service Offices around the country do. A few differences are that our office handles the Disabled American Veterans (DAV) van that transport veterans to both the Danville IL VAMC and the Indianapolis Roudebush VAMC as well. Four years ago I was able to convince the Lafayette Journal & Courier to allow me to publish a bi-weekly article informing veterans of their VA benefits. This information reaches approximately 28,000 veterans in a 7-county area. Besides assisting veterans with processing VA claims and helping them with obtaining their VA medical care, our

office handles the distribution of American flags to our local organizations that assist us with placing US flags in cemeteries and numerous other activities that keep us busy.

I have been asked to appear today provide you information concerning the quality of care and management issues at Roudebush VAMC and on the management and delivery of benefits by the Regional Office for Benefits. In working at the grassroots of the system, Jackie and I are probably the first ones that a veteran complains to concerning any VA problem be it medical or claims processing. My testimony will not be in the style of "he said, she said" but in trying to help you understand how the 80-year old WWII veteran to the youngest veteran sees the VA. I would like to begin with VA medical care and the delivery of that care:

- 10-10EZ Form: With no disrespect to our veterans, this form is not EZ enough, from the colored chart on the front page, to the financial disclosure on the back this form is insurmountable for many of our older veterans. This form is in many cases the first contact a veteran may have had in years with the VA.
- Veterans Universal Access Identification Card: Veterans in northwest Indiana are confused when they decide to transfer from receiving medical care at Roudebush VAMC to the West Lafayette Community Out-Based Clinic (CBOC) that they have to re-enroll with the VA. Their comment is "the VA already has this information". When the VA is constantly requesting financial information from our veterans this helps foster a feeling of mistrust among them. The Universal ID card needs to become a better tool for the VA to assist veterans. Mr. Gobel presented the Danville VA Medical Center with this card in February 1996 and very little improvement has been made since that time.
- Appointments: The vast majority of veterans are extremely frustrated by the length of time it takes to get an appointment in specialty clinics and how often their scheduled appointments are changed at the last minute. Our office normally has 3 or 4 veterans a week come in and ask us to call the appropriate VA Medical Center to see when their next appointment is scheduled. Speaking only of the West Lafayette CBOC, staffing of the clinic has been a major obstacle. Currently, the CBOC is not taking new veteran enrollees. Hopefully, this is only temporary, but I feel that one of the problems facing VA recruitment of healthcare providers is the length of time between the person filing an application for employment and their starting date. Normally, during that period of time healthcare providers will find employment elsewhere.
- Medicare Subvention/Co-Managed Healthcare: By far the greatest challenge facing County Veterans Service Officers and the many others who are assisting our veterans is educating them about this program. The

current system has veterans receiving healthcare from both their private doctor(s) (subsidized by Medicare) and the VA doctor (paid by the government) so that they can receive their prescriptions at a reduced rate. The veterans cannot understand why the VA will not honor their private doctor's prescription. So in essence, veterans are having Medicare deducted monthly from their Social Security and then if they are found to be over the VA income threshold, they're charged a $50.80 co-pay to be seen again for the same injury or illness that their private doctor just saw them for. With the VA depending on this co-pay and collections from third party payees (insurance companies) many veterans feel that they are having appointments made just for the VA to fatten their coiffures. Many veterans are told by their private doctor that they don't need be seen for a year, while the VA doctor wants to see him in 6 months or earlier. In the Co-Managed healthcare program, veterans are quickly wedged between their private doctors and the VA doctors of who is right or wrong. The veterans want to continue to see the doctor that they have seen for years, while at the same time be able to continue to receive their medicines through the VA. With Category 7 veterans not being assured of VA Healthcare from one year to the next this puts them in a tight spot. I have found that whenever this discussion comes up with VA Healthcare providers that they are quick to say, "We're not a pharmacy, we are healthcare providers". I feel that our veterans have been made scapegoats on this issue. The VA has offered them a carrot on a string with the offer of cheaper prescriptions as long as they play according to VA rules. Congressman Buyer and Congresswoman Carson, I ask your help in changing the federal law that prohibits the VA from billing Medicare for treatment of our veterans. I feel that if Congress picks up steam on their proposal of offering senior citizens prescription coverage that the VA will lose a tremendous amount of the Category 7 veterans currently enrolled. Most veterans who contact our office or the local CBOC, their first question is "Is this where I can sign up for my medicines?" In many circumstances our veterans are asking for only a portion of their benefit, and that is their prescriptions.

I would like for us to turn our attention to the Indianapolis VA Regional Office (VARO). During my 6 years as serving as the Tippecanoe County Veterans Service Officer, our office has had almost daily contact with the Indianapolis VARO. Jeff Alger, and his predecessor Dr. Dennis Wyant and their staff have continually provided our office and our veterans superb support. My office with the help of other local organizations has hosted 4 Veterans' Expos (an event that brings veterans services to the local area) and the Indianapolis VARO has supported these events in an outstanding manner. As stated earlier I am at the grassroots of the VA claim processing system, so I don't have the most recent numbers on staffing, budgeting, the amount of claims adjudicated, etc. But, I am in a position to know that probably more

than anymore else, the VAROs have been asked to do much more with less. It is encouraging to know that Mr. Alger is now in a position where he can hire additional personnel. I would like to take a moment to address of few areas that could possibly improve the VA's ability to provide service to our veterans.

- Education: It's imperative both the staff at VAROs and County Veteran Service Officers (CVSOs) are educated thoroughly on each other's role in assisting veterans. Being a CVSO you're never quite sure where you fit in VA. At times the VARO is quite willing to assist you with information concerning a claim for a veteran and at other times the reply is that we can only talk to the veteran. I would like to ask for your assistance in developing a more consistent policy on this issue.
- Forms: As I mentioned earlier about the 1010-EZ forms, the forms currently being used by the VA (particularly VA Form 526) is certainly not consumer-friendly. Counting the instructional pages this form is 22 pages. Only a few veterans have visited our office to pick up the forms necessary to submit a claim that has not returned for assistance.
- Claims Process: In a perfect VA and CVSO world, the veteran would arrive at our office with a copy of his DD Form 214, copy of his service medical records (showing the veteran's disability) and current medical records (showing that the veteran still has the disability) and all marriage licenses, birth certificates, etc. The claim is submitted and a couple days later it's adjudicated. However, when reviewing our current active files, the most obvious reasons I see for claims not being adjudicated in a timely manner is that the veteran has not returned with the documents needed, has moved without notifying the VA or in some cases the claim may have been denied numerous times and the veteran continues to re-file. It is important that the initial claim be submitted properly and with all of the evidence needed. In dealing with claims that seem to hit a roadblock, I have found the Indianapolis VARO to be only a phone call or an e-mail away to resolve the problem.

In closing, I would like to state that there are many veterans' advocates throughout the State of Indiana and I would be remiss not to mention the staff of the Danville IL VAMC that are very pro-active in assisting our veterans with both their medical care and their other VA benefits. Hopefully, by continuing to work together we can continue to strive to assist our veterans even better.

It is an honor to serve our Indiana veterans. Thank you for your time.

TESTIMONY
BY
WILLIAM D. JACKSON
DIRECTOR
OF THE
INDIANA DEPARTMENT OF VETERANS AFFAIRS
TO THE
SUBCOMMITTEE
ON
OVERSIGHT AND INVESTIGATIONS
FIELD HEARING
SEPTEMBER 5, 2001
INDIANAPOLIS, INDIANA

Mr. Chairman and Members of the Committee:

I appreciate the invitation to appear and present testimony concerning the quality of care and management issues at the Richard L. Roudebush VA Medical Center, and concerning the management and delivery of benefits by the Regional Office for Benefits in Indianapolis.

As Director of the Indiana Department of Veterans Affairs I have a vested interest in both of these areas. But, first, I want to thank the Directors of both facilities for their cooperative effort in working with our Agency to identify the needs of Hoosier veterans and then provide those veterans with high quality care and service.

Your Committee and Secretary Principi may or may not be aware of an outreach program for veterans that our Lieutenant Governor Joe Kernan started four years ago.

Joe was a former Navy pilot serving during the Vietnam War, and was shot down over North Vietnam and spent a year as a Prisoner of War. It was not until he became Lieutenant Governor and he and I were visiting the Roudeush VA medical facility that we had a discussion about veterans' benefits. He then discovered that he was eligible for many benefits of which he was not aware. He made a commitment that day to insure that every effort be made to inform the veterans and their families in our State about the benefits to which they are entitled.

Working with the Regional Office and the Medical Center we have mailed over 70,000 brochures and held numerous seminars and conferences. The staffs of the VA Regional Office and Medical Center here in Indianapolis have participated and have been an integral part of this program.

I, personally, feel that the veterans in Indiana are fortunate to have the dedicated staffs and quality of services provided by both the VA Regional Office and the Roudebush VA Medical Center.

Regarding complaints on quality of services from either facility, the most common one I receive is the length of time it takes for a veteran to get an appointment to see a doctor. That time span has been running about six (6) months – which I, personally, feel is too long. It is going to be difficult to resolve that problem unless Congress has a group of doctors they are hiding and ready to place in our Medical Center.

I am concerned about resources for our Region. I understand that our Region, based on the President's budget for FY02, is projecting a deficit of 33 million dollars. Obviously, if this is correct, cuts will have to be made, and this could affect the quality of services provided to our veteran population.

In summary, overall our Agency is pleased with the management and quality of care being provided to veterans by both the VA Regional Office and the Roudebush VA Medical Center, with the exception of the one area mentioned above.

My staff and I look forward to facing the challenges of not only the Federal VA System but to those we encounter in State Government as well. We will address them as a partner in a cooperative manner – just as we have for the past 4-1/2 years.

Again, I appreciate being given the opportunity to be here today and provide you with some information from State Government.

STATEMENT OF

JAY A. KENDALL

VETERAN SERVICE OFFICER OF MIAMI COUNTY

BEFORE THE COMMITTEE ON VETERANS' AFFAIRS

SUBCOMMITTEE ON OVERSIGHT AND INVESTIGATIONS

U.S. HOUSE OF REPRESENTATIVES

SEPTEMBER 5, 2001

Mr. Chairman and members of the Committee.

I am honored to give you a snapshot of how the VA is helping Veterans in my area. Overall the Veterans I work with are pleased with the service they receive from the Regional Office and the Medical Centers.
Locally, I work at the "pointy edge of the spear". I am the person that Veterans can go to and ask questions and receive help. Since Grissom was deactivated I have many, many retirees and Vets that are more than just a little sore. But lately I have received a steady flow of Vets looking for one thing. Help from the skyrocketing pharmacy bills. Our government did a good thing to open up healthcare to all Veterans several years ago… But like all good things it can develop new problems. The growth rate for Northern Indiana VA healthcare has been averaging 20% a year. This year the rate is closer to 29%. Gentleman the word is out. The VA healthcare can help. I work with very proud, very stubborn veterans and they are coming to my office asking for help. But local VA Medical Centers are now realizing they can not handle the influx of new Veterans. According to VISN 11 information in 1999 only 11% of the Veterans were using the medical services. How is the VA Medical Center going to handle a larger percentage?? Let me give you an example. Just over a year ago the word was that a Veteran could walk into a VA Medical Center with his discharge in hand, fill out the forms, see a doctor and receive medicine all in the same day. Now we have to tell the Veteran that there is a 90-day wait before a doctor can see him. A year ago there was flexibility in the system now there is none. If I have to change an appointment for a Vet it could result in a delay of 6 to 8 weeks before that Vet could get another appointment.
One of the major problems is that the VA can not compete with the private industry in hiring qualified healthcare personnel like doctors, nurses, and pharmacists. The Northern Indiana VA Healthcare system currently has 135 open slots in a workforce that total 1160 that means almost 12% of their workforce is missing. More with Less can work in some areas but not in Healthcare. But let me state that the nurses and technicians in the system now are really working hard and I rarely have any complaints.

More and more of Medical Centers budget money is going to pay for all the medicine they must obtain. Congressman, this is how Congress must get involved. Sooner or later, and I am betting sooner, the system is going to break and there is no easy solution. More and more Vets are relying on VA healthcare and the VA can not lessen the quality or quantity of healthcare… it is all or nothing.

The following are some problems I see at my level:

1 Formulary Drugs
Not all medical centers have the same formulary list. This must be changed. How is it fair for a Vet in one state or even in the next hospital to get a prescription while the next Vet can not?
The list must be more receptive to newer medicines. Louie Myers has waited over two years to get Celebrex from the VA. Other medicines do not work as well, but the VA is so slow to get new drugs. Doctors state that you, the Vet, must get approval from someone higher to get the medicine. Doctors should not be constrained by administration when trying to reduce pain or heal a Vet. I ask that you direct the VA to enforce a national formulary at all VA Medical Centers.

2 Transferred files / computer between medical facilities is improving but still has a long way to go. For example between Ft Wayne and Marion VAMCs there is very good coordination but between these two facilities and Indianapolis it is difficult. My example is a year old but still emphasizes my point. Lee Brewer was transferred from Marion to Indianapolis VAMC with a growth on his lungs. The X-ray files were lost en-route and the decision to give him medication and radiation was delayed and possibly as a result the only course of action after the files were found was to remove his lung. Sometimes it seems like Indianapolis has a "me first" attitude with their Veterans when all Veterans in the state rely on Indianapolis for specialized care. I request you direct the VA to not prioritize local patient over patients from the outlying regions for specialized care.

3 Another item of great importance is the VA attempt to use Community Based Clinics(CBOC). This is a good thing. All the Vets that I have talked with really like the system in its current state. The challenge is that the VA is very slow in assigning/increasing the number of CBOCs. Can you ask them to speed it up??… I have, but it would be better coming from you. At the last County Veteran Service Officer's meeting, Dr. Lanier, MedMark Services Inc., stated if he could get VA approval he would put 40 clinics in Indiana. There are only 6 now. The CBOC in Muncie was established in about 45 days and is providing a great service to the Vets. I request that the VA expand the number of CBOCs as soon as possible.

The following are the hardest things for me to do as a Veteran Service Officer

1. Tell a W.W.I Vet that the VA still does not have a comprehensive long term care procedure.

2. Explain to a widow that she must be living below the poverty level in order to qualify for widow's pension.

3. Tell a Viet Nam Vet that the VA has only limited support for Agent Orange or the Desert Storm Vet that there is no support yet for Gulf War syndrome.

4. To tell a Vet that he can not prove his case because the fire in St Louis destroyed his records and there is no supporting evidence.

5. Explain to disabled, military retirees how they are not allowed to receive concurrent pay like other Federal Employees do.

The VA thinking and current attitude is to do "more with less". It is impossible to provide healthcare with less. The VA is doing a good job today, Congress must realize the important contribution the VA is making and continue to increase funding for the VA.

I enjoy helping the Veterans in my area. I hear war stories that water my eyes. Congress has some big decisions on how much care the VA can give to all the Veterans signing up. I want to be able to tell Vets that the VA is there to help them.

This concludes my statement.

Statement of
John J. Michalski, Commander
The American Legion Department of Indiana

Before
The US House of Representatives'
Veterans Affairs Subcommittee on Oversight and Investigation

September 5, 2001
Indianapolis, Indiana

Mr. Chairman, members of the Subcommittee...

Thank you for the opportunity to present the views of The American Legion Department of Indiana on quality of care and management issues at the Indianapolis VA Medical Center ... and on claims processing issues at the Indianapolis Regional Office.

Our organization recognizes and appreciates the efforts of this committee, the VA, and Congress to substantially improve the quality and access to medical care of veterans over the past several years. Since enactment of Public Law 104-262 – the Veterans Health Care Eligibility Reform Act of 1996 – veterans in all seven eligibility categories have been entitled to a full and comprehensive package of health care services from VA Medical Centers.

The Indianapolis VA Medical Center is a prime example of excellent delivery of services by the VA. It provides a full range of health care services and does so in a friendly and courteous manner. We rarely receive complaints concerning the quality of its services.

However, we do have one significant local concern: A few years ago, The American Legion Department of Indiana chose not to oppose VA's plan to close the Cold Springs Road VA facility here in Indianapolis. That facility provided long-term nursing home care, and care for mental health patients. The VA had entered into an agreement with the State of Indiana, which provided for the State to either lease or purchase the Cold Springs Road facility ... and consequently, to use the proceeds of the sale or lease to expand services – particularly nursing home care services -- at the remaining VA Medical facility here in Indianapolis.

This apparent win-win situation would benefit the VA by relieving it of the burden of maintaining two VA medical facilities ... and nursing home and mental health patients by providing direct access to physical medical care without having to endure a transfer between hospitals.

Nevertheless, several years now have passed and there has been no expansion of services for nursing home patients and mental health patients at the remaining VA Medical facility here. We know that the original agreement -- which the Indiana American Legion supported in good faith – netted the Indianapolis VA Medical Center approximately three million dollars. That money has not been used and has since increased to about 3.3 million dollars.

We also understand that this area's Veterans Integrated Service Network – No. 11 – is facing a deficit in excess of 30 million dollars. It is our concern that the VISN may attempt to reduce its budget deficit by attaching the 3.3 million dollars meant for local veterans. Those veterans have already given up an entire VA medical facility for unfulfilled promises.

Beyond the initial three million dollars, the VA medical care system no doubt has saved millions more in recurring expenses that they have not had to meet. VA should apply the original proceeds toward meeting its commitment to local veterans, and expand nursing home and mental health services at the remaining VA medical facility here.

Despite this concern, we do acknowledge that one huge improvement in the system has been the expansion of the Outpatient system. However, the inconsistency from one outpatient clinic to another is very apparent. We were told once a patient was in the system, any outpatient clinic would accessible and this is not true.

In Secretary Principi's speech to The American Legion National Convention in San Antonio, he mentioned the organization of teams to clear up old claims. This is commendable, but what is being done to see that the age-old problem of claims is being rectified?

One might think that the Veterans Benefits Administration can do nothing right. Complaints are everywhere:

- Some say the VBA first provides too little information about a decision – then it provides too much.

- Some say the VA should make a decision quickly without waiting for so much evidence, while other complain that the VA made a decision on their cases without assisting enough in helping them find evidence – which the VA is now mandated by law to do.

- Some say that VA employees lack proper training; other say VA can get nothing done because VA employees are always in training.

- Some complain that VA letters contain too little information; others say VA letters are too confusing because they contain too much information.

Obviously, both sides of these issues cannot be right. But it does clearly demonstrate that the claims process is poorly understood by most veterans.

Locally, we understand the VA Regional Office has hired more VBA employees. This is long past due. When the VA Regional Office decides to work on improving one area of claims processing, such as, new claims, it fall behind in working other areas of its responsibilities, such as, the processing of appealed cases.

We only hope that VA will properly train its new employees, see them as a long term investment in America's veteran, and avoid the temptation to discharge more experienced VBA employees with buy outs.

The American Legion Department of Indiana encourages the VA to continue to work on this area.

Ladies and Gentlemen, that concludes my testimony. I would be happy to answer any questions you might have about our views.

Thank you.

Statement of

Linda Belton, Director

Veterans Integrated Service Network (VISN) 11

Veterans Health Administration

Department of Veterans Affairs

Before the

Subcommittee on Oversight and Investigations

Committee on Veterans' Affairs

U.S. House of Representatives

September 5, 2001

Mr. Chairman and Members of the Committee, I have been invited to discuss Veterans Integrated Service Network (VISN) 11; the VA Medical Center, Indianapolis, Indiana and the Northern Indiana Healthcare System, Marion and Ft. Wayne, Indiana.

VISN 11 provides services throughout a large and geographically diverse region, across the lower peninsula of Michigan, northwest Ohio, most of the state of Indiana and central Illinois. Nearly 1.5 million veterans reside within the Network service area, representing 6% of the nation's veteran population; approximately 37% are priority 1-6 veterans. In 2000, we served nearly 155,000 veterans, with 86% of these veterans in Priorities 1 through 6. Through May 2001, the network enrolled more than 206,000 veterans.

The mission of this network is to be an integrated veterans healthcare system providing high quality, coordinated, comprehensive and cost-effective services to veterans and other customers in Michigan, Indiana, central Illinois and northwest Ohio. At the Department level, the network is a key player in meeting VA goals regarding veteran satisfaction, access, cost effectiveness, expanded primary care service and service integration to provide a seamless continuum of care.

Over the past two years, Congress has increased the VHA medical budget by approximately $3.5 billion. At the same time, decisions surrounding eligibility reform and definition of the VA basic benefits package have introduced the opportunity for large numbers of veterans to enroll with VA and obtain access to a broad range of services.

Budgetary considerations and other performance goals are driving all networks to find ways to provide care more efficiently. Critical network activities in the areas of Quality, Cost, Access and Communication are as follows:

Quality

All network facilities participate in nationally recognized external accreditation processes, including Joint Commission on Accreditation of Healthcare Organizations (JCAHO), Commission on Accreditation of Rehabilitation Facilities (CARF) and College of American Pathologists (CAP). The most recent JCAHO survey process was conducted in this network in the fall 2000, with hospital accreditation scores ranging from 86 to 93. Network medical centers with rehabilitation programs are proceeding with CARF accreditation; to-date Indianapolis and Northern Indiana Healthcare System have been accredited.

Numerous activities are underway to improve waiting times in all clinics. Network facilities participated in a collaborative initiative with the Institute for Healthcare Improvement (IHI) to decrease waiting times in clinics and delays for veterans obtaining appointments and have initiated numerous actions in this regard. While some improvements in waiting times have been achieved, increased demand for service, space limitations, critical staff vacancies and resource constraints continue to present challenges. Of note, is the current network average wait time of 40 days in Primary Care, with wait times in the high demand clinics of Cardiology and Orthopedics at 51 and 54 days, respectively.

In 1998, VA launched its National Center for Patient Safety, designed to apply "systems approaches" to patient safety. Some specific actions taken to-date include implementing bar coding for medication administration and computerized order entry. The objective of the current patient safety program is to identify system problems and solutions, not to assign fault to individuals. In FY00 and continuing this fiscal year, an extensive staff education and training program was implemented to develop skills in identifying sentinel events and conducting root cause analyses. Additionally, staffs from VAMC Indianapolis and Northern Indiana have participated in 14 educational sessions entitled Preventing and Managing Disruptive Behavior.

VHA has also undertaken an aggressive performance measurement system, including establishing baseline performance and outcome goals in the areas of prevention, clinical guidelines and chronic disease management. As we all know, preventing illness and successfully managing chronic disease processes improve not only the efficacy of care provided, but also the patients' quality of life. A veteran satisfaction performance measure closely monitored in this network is pharmacy waiting times, with a goal of 30 minutes or less to wait for a prescription to be filled. For the twelve-month period ending June 2001, VAMC Indianapolis averaged 31 minutes, the medical center at Marion averaged 30 minutes and the medical center at Ft. Wayne averaged 24 minutes.

Cost

The 22 Networks receive appropriated funds from VA Central Office through the Veterans Equitable Resource Allocation (VERA) model, as well as specific allocations for special purpose funding, e.g. prosthetics, and for research and medical education support. The VERA model is based on inpatient and outpatient workload in program areas of medicine, surgery, psychiatry and long-term care. Adjustments are made for geographic pay differences as well as variable costs in education and research.

From FY 1996 to FY 2001, the network's operating allocations through VERA have increased by 12.2%. These allocations do not include capital allocations, which increased by 28.9% for the same period. Since inflation and pay raises have exceeded the increases in our operating allocations, the network has not been able to keep pace with inflation as well as absorbing national mandates. The Network has responded to budgetary challenges by shifting care to less costly settings, developing a continuum of care across facilities to reduce unnecessary duplication, closing unneeded hospital beds, standardizing supplies and pharmaceuticals, and expanding use of blanket purchase agreements. The Network has worked to stabilize its future funding allocations by increasing the number of veterans utilizing its services. To illustrate, the Network treated approximately 155,000 veterans during FY00, an increase of 26,400 veterans from FY96. Outpatient visits increased by 265,000 during the same time period, while hospital operating beds showed a decrease from 2,860 to 1,102. In order to meet the projected health care needs of veterans, VISN leadership continues to address efficiencies such as

standardizing volume contract purchases, leveraging resources through partnerships, and the expanded use of information and other technologies.

VISN 11's FY01 budget allocation was $721 million. Critical network initiatives, e.g., CBOCs, leases, special projects, employee education, fire and safety program and national program support were funded at a level of $10 million. Prosthetics special purpose funding as distributed from VA Central Office totaled $26 million in FY01. Research and Education support funding are passed-through to facilities as allocated to the network from VA Central Office.

Budget distribution from the network to facilities (Ann Arbor, Detroit, Battle Creek, Saginaw, Northern Indiana, Indianapolis, and Illiana) for FY01 was based on FY00 actual expenditures, plus 5 to 5.5% percent increases. VISN 11 maintains a reserve of approximately 2% of the operating budget to ensure funding for unexpected shortfalls due to increased workload, catastrophic patient care needs and acts of nature such as weather-related emergencies.

On the revenue side, collections from the Medical Care Cost Fund (MCCF) program totaled $26.4 million in 2000, with a projection of $34 million in 2001. Collections at VAMC Indianapolis and Northern Indiana Healthcare System increased 61% and 43%, respectively over the same period last year. Money collected by the medical centers through the MCCF program are available to the medical centers upon allocation by the Secretary.

Access

VISN 11 has moved significantly from a healthcare delivery system traditionally rooted in inpatient care to a more outpatient-based system. An integral part of the expansion of outpatient access is the establishment of new Community-Based Outpatient Clinics (CBOCs). VISN 11 has 23 CBOCs currently operational, with one additional CBOC expected to open in Michigan this fall. This brings 85% of veteran users in our Network within 30 miles of a VA primary care site. Five of these twenty-three CBOCs are located in Indiana, at South Bend, Muncie, Bloomington, Lafayette and Terre Haute. The Lafayette CBOC is co-located at the Indiana State Veterans Home. While the primary care workload plans for the CBOCs ranged from 1000 to 1500 patients per year, almost all of the CBOCs have met or exceeded their planned capacity. Terre Haute,

South Bend and Muncie have already seen more than 3,000 unique patients this year, with Bloomington and Lafayette treating another 2,000 each. In FY01, the network also budgeted $1 million to expand mental health services to each CBOC. Implementation of these services has begun this quarter of the fiscal year with services to be provided, as needed, by psychiatrists, psychologists, social workers and/or advanced practice nurses. The planned expenditure for mental health services in Indiana CBOCs is $400,000 annually.

In response to the requirements of the "Veterans Millennium Health Care and Benefits Act," VISN 11 has established plans to increase VA nursing home average daily census by 82 by the end of 2003. Plans include improved staffing levels and reallocation of staff, increased patient referrals to VA nursing home units, and redesignation of some long-term care unit beds as nursing home beds based on evaluation of current patient needs. In Indianapolis, enhanced use plans for the construction of a private sector nursing home on VA grounds is also proceeding. Long-term care needs are addressed across the network through a combination of VA nursing home, contract nursing home, state veterans home, home-based primary care, and purchased home- and community-based services.

Investments in information technology will also have positive impacts on access, timeliness and quality. VISN 11 telemedicine initiatives include telepsychiatry, teleopthalmalogy and teleradiology pilots and telehome care.

This fall, VISN 11 will take part in CARES (Capital Asset Realignment for Enhanced Services), a process to evaluate how well VA's capital assets link with current and future mission. This may result in structure and mission changes across the network.

Communication

Communication with stakeholder groups is of high priority throughout the network. In order to assure these communications across all care sites, the network has designed an annual Veteran Service Officer (VSO) Forum. The first Forum was held in December 1997 with approximately 75 national, state and county service officers in attendance. The program grew to over 100 attendees at the 2000 Forum. These Forums cover a wide variety of topics important to veteran groups including eligibility, womens' health, service line development, program changes and access.

VISN 11 staff work closely with colleagues in the Veteran Benefits Administration (VBA) regional offices in Detroit and Indianapolis to meet veterans' needs regarding compensation and pension (C&P) examinations. C&P processing times are consistently below the national standard of 35 days and were at 33 days through May. In the network, 99% of C&P exams are found adequate for rating purposes by the regional office rating boards. In a collaborative effort to continuously improve performance, VHA and VBA officials in this network developed joint performance standards to reduce incomplete C&P examination rates and to provide training to VBA rating specialists in the use of electronic medical record information.

In 1999, the network implemented a network award and recognition program in partnership with American Federation of Government Employees (AFGE) and Service Employees International Union (SEIU) labor officials. In the past 12 months, VAMC Indianapolis has been recognized for achievement with Multicultural Workplace, Process Improvement, Employer of Choice and Provider of Choice awards. During the same time frame, Northern Indiana Healthcare System has been recognized with Multicultural Workplace and Provider of Choice awards. These awards reflect a high degree of staff commitment and service excellence.

Closing Comments

The Indianapolis VA Medical Center and Northern Indiana Healthcare System play integral roles in VISN 11's healthcare delivery system, providing primary, secondary and tertiary care. As a system, programmatic changes such as shifting from inpatient to outpatient care, consolidating some business and support functions, and discontinuing under utilized programs have thus far been accomplished through the use of early retirement and buyout authority, and by offering displaced employees alternative positions, including necessary retraining. We recognize the need to establish and maintain a safe environment for patients and employees as changes are implemented. The best patient care can only be delivered when patients and staff are comfortable and secure. In a recently reported American Legion survey of veterans, quality, access and satisfaction were ranked as the top three factors of value in healthcare. For VISN 11, quality and satisfaction were rated good or excellent by 80% of respondents and access was rated good or excellent by 75% of respondents.

VISN 11 continues to face a number of challenges including managing within appropriated funding; exercising stewardship of all resources; increasing market share; continuously improving quality of care and veteran satisfaction with that care; fully integrating administrative and clinical programs and processes; investing in capital improvements and information technology; and effectively communicating with veteran groups, labor partners, educational affiliates and other stakeholders. I am confident that the staff and leadership of the Indiana VA facilities are equal to those challenges.

Statement of

Michael W. Murphy, Ph.D.

Director, VA Northern Indiana Health Care System (NIHCS)

Veteran Integrated Service Network (VISN) 11

Veterans Health Administration

Department of Veterans Affairs

Before the

Subcommittee on Oversight and Investigations

Committee on Veterans' Affairs

U.S. House of Representatives

September 5, 2001

Mr. Chairman and members of the Committee I have been invited to discuss, access, enrollment, funding/budget, recruitment and retention, and program changes. The VA Northern Indiana Health Care System (NIHCS) is dedicated to serving America's veterans and ensuring that they receive the medical care benefits they deserve.

The VA Northern Indiana Health Care System is comprised of VA Medical Centers in Fort Wayne and Marion, IN, and Community Based Outpatient Clinics (CBOC) in South Bend and Muncie, IN. VAMC Fort Wayne is a primary and secondary medical and surgical facility, with an outpatient clinic, located in the second largest city in Indiana. VAMC Marion is a psychiatric and long-term care facility with an outpatient clinic, and serves as the neuropsychiatric referral facility for the entire state of Indiana.

The veteran catchment area for NIHCS includes 28 counties in Indiana and 7 counties in Ohio. The Marion campus serves as the neuropsychiatric referral facility for Indiana. The two campuses are separated by 60 miles and provide complementary services. Medical and surgical services are available at the Fort Wayne campus, psychiatry and extended care are provided at the Marion campus. Primary care clinics are available at both campuses. Inpatient services are provided in the 243 authorized hospital beds and 180 nursing home care beds. A contracted Community-Based Outpatient Clinic (CBOC) was opened in the South Bend-Elkhart area of Indiana, in April 1998. This contract was re-bid in the spring of 2001 with a new contractor taking

over this past May. In August 1999, a second NIHCS CBOC was opened in Muncie, IN, providing area veterans convenient access to primary care services. We are providing basic mental health services at both CBOCs, through a contractor at South Bend, and VA personnel at Muncie. Both CBOC operations have an enrollment of approximately 3500 veterans, and are attracting over 100 new enrollees per month.

NIHCS also provides administrative support to a veteran's readjustment counseling center (Vet Center) in Fort Wayne and to the Marion National Cemetery.

Although the Marion campus is well over 100 years old and the Fort Wayne campus was constructed in the 1950's, recently completed renovation and construction projects ensure a modern and attractive state-of-the art healthcare environment. A 240-bed gero-psychiatry building was occupied at the Marion campus in July of 1997 and a 100-bed general psychiatry building was activated in the fall of 2000. A new ambulatory care addition was opened in November of 1998 at the Fort Wayne campus.

NIHCS is fully accredited by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) in the Hospital Accreditation Program (HAP), Home Health Care, Long Term Care, and Behavioral Health Care. Our most recent cyclic JCAHO survey in December 2000 resulted in scores of 86, 97, 97, and 100 respectively. We are also fully accredited by the College of American Pathologists (CAP), the Commission on Accreditation of Rehabilitation Facilities (CARF), and the Nuclear Regulatory Commission (NRC).

A Combined Assessment Program (CAP) Review by the Office of Inspector General (OIG), Department of Veterans Affairs was conducted at NIHCS, March 6-10, 2000. The OIG made a return visit in October 2000 to review our progress and the status of actions taken. As of May 2, 2001, the OIG closed the report based upon our responses and information provided concerning actions taken on their recommendations. We invited an outside consultant, Dr. Andrea Conti-Wyncken, faculty member Indiana University School of Medicine, Chief of PM&RS, Indianapolis VAMC, and a surveyor for the Commission on Accreditation for Rehabilitation Facilities (CARF), to come in and review our Sub-Acute Rehabilitation program. Her report offered some suggestions to improve our program, but did not recommend any consolidations or realignments. Our Nursing Home Care Unit operations were reviewed by the Boston HSR&D,

Management Decision and Research Center (MDRC). Their report recommended that all NIHCS Nursing Home Care operations be consolidated at the Marion campus. We have discussed this issue with stakeholders and have received VACO approval and have implemented the change to provide all inpatient Nursing Home services at the Marion campus.

The inpatient medicine unit at the Marion campus has been experiencing a decreasing average daily census (ADC) over the past few years; it was 5.9 in FY00 and is 6.0 through July of FY01. After reviewing patient needs, options for inpatient medical care, costs, and the need to maintain staff competencies we have decided to close that unit. The targeted closure date is October 1 of this year. Stakeholders have been informed and VACO approval has been obtained. Veterans presenting at the Marion campus in need of inpatient medical care will be transferred to Fort Wayne, Indianapolis VAMC, or the local community hospital, as appropriate.

The emphasis at NIHCS continues to be on providing high quality health care services for all veterans in the appropriate clinical setting. We have expanded our efforts in serving homeless veterans by partnering with a provider in the Anderson area, through the Homeless Provider Grant and Per Diem Program. Additionally we work closely with the Homeless Task Force of Fort Wayne in supporting "stand downs" and other essential homeless services. Our Home Based Primary Care (HBPC) program provides in-home primary medical care services to home-bound veterans with chronic diseases and terminal illnesses. Our Adult Day Health Care program provides psychosocial health care services and rehabilitation to veterans in an outpatient setting. Our Respite Care program provides care givers brief periods of needed relief from the responsibility of providing 24-hour care to their loved ones. We are working closely with the Indianapolis VAMC Psychosocial Residential Rehabilitation Treatment Program to identify and return long term psychiatric inpatients to a community setting.

The shift in emphasis at NIHCS, from a hospital-based healthcare system to an ambulatory care, outpatient focused system, has resulted in improvements in the access and delivery of quality health care for our veterans. This shift is consistent with the current delivery paradigm in the private sector and more specifically within the VA in medical, surgical, psychiatric and mental health care. Recruitment of nurses,

pharmacists, and certain types of medical technicians has become increasingly difficult due to nationwide shortages and increased competition for these specialties.

- Total inpatient hospital bed days of care (BDOC) have declined by over 20% per year (FY99 - 91,514; FY00 - 70,692; FY01 - 51,117 *estimated*). Conversely, Nursing Home Care beds days of care have been increasing from 34,436 in FY99; to 39,961 in FY00; to an estimated 45,000 this FY.
- The average length of stay (ALOS) in acute medicine has been reduced from 6.31 days in FY98 to 5.14 days in July 2001. Adjusted for age and diagnosis, our ALOS is comparable to that in the private sector.
- The total number of outpatients treated per year continues to increase at about 20% each year, from 15,014 in FY99 to 18,086 in FY00 with an estimated 23,000 this fiscal year.
- Due to the increasing number of veterans being seen and the costs of current medications, our pharmacy expenditures have increased from $7.5 million in FY00 to $12.1 million in FY01 and we expect this to increase to $18 million in FY02.
- Over 7,000 veterans are currently receiving their outpatient primary medical care at our CBOCs in South Bend and Muncie.
- Currently over 90% of our surgeries are performed in an ambulatory/outpatient setting.
- Program changes and workload shifts from inpatient to outpatient care, have allowed us to increase our direct care positions at NIHCS by 25.8, while actually reducing non-patient care staff by 8.1 positions during FY01.
- Our inpatient Substance Abuse Treatment Program (SATP) was converted to an outpatient model early in FY99. Federal and private health care studies have revealed that more successful outcomes are obtained in outpatient treatment models that emphasize patient commitment and provider support compared to those obtained in the traditional inpatient setting. The SATP professional team carefully monitors patient care and provides care management; coordinating services with veterans, families and community providers.

- Our inpatient program for patients diagnosed with Post Traumatic Stress Disorder (PTSD) was converted to an outpatient program for those patients not otherwise requiring hospital care.
- A Mental Health Intensive Case Management (MHICM) program was started in FY 1999 in an effort to return and maintain patients to a community setting. VISN 11 provided a grant in FY01 to implement a psycho-social rehabilitation model that will improve community rehabilitation efforts and train our providers in community placement programs. The driving force of this program is to improve the quality of life and the quality of care for those veterans whose psychiatric care does not require that they be treated in an institutional setting.
- NIHCS received two, two-year grants from VACO in FY01 to establish outpatient Substance Abuse and Post Traumatic Stress Disorder treatment programs at the Fort Wayne campus to better serve the large veteran population of northeast Indiana, particularly those veterans residing in Fort Wayne and Allen County.
- NIHCS reviewed the steam distribution needs at the Fort Wayne campus and developed a project to change our boiler plant from high pressure steam to low pressure steam distribution. This project was completed in the fall of 2000 and will result in ongoing savings that have a payback of 3 to 4 years.
- NIHCS is working closely with the Indiana Department of Natural Resources to develop a plan to demolish unoccupied and unused buildings on the National Historic Register at the Marion campus. Most of these buildings are nearing or over 100 years old and are very inefficient to operate and maintain. The demolition of these buildings will provide for better utilization of the land and increased potentials for enhanced use partnering with private and commercial sources.

We are continuing to work together with our labor partners to provide a workplace that is employee friendly. Regular, recurring meetings are being held between top management and the leaders of both AFGE locals to ensure communications are open and substantive.

NIHCS supports the Veterans Health Administration, and VISN 11 in developing programs for veterans consistent with the six nationally adopted domains of value:

Quality, Cost, Access, Satisfaction, Functional Outcomes and Community Health. We are committed to providing America's veterans the highest quality health care in the most cost effective manner and in the least restrictive clinical setting. We have an equivalent commitment to our employees to improve communication and participation in implementing new programs. The many changes that have taken place at NIHCS and that will be necessary in the future have a significant impact on employees in terms of how they do their jobs, the settings where care is provided, the skills sets necessary to do the quality work we all strive for, and overall job satisfaction.

Statement of

Robert H. Sabin, Director

Richard L. Roudebush Veterans Affairs Medical Center

Veteran Integrated Service Network (VISN) 11

Veterans Health Administration

Department of Veterans Affairs

Before the

Subcommittee on Oversight and Investigations

Committee on Veterans' Affairs

U.S. House of Representatives

September 5, 2001

Mr. Chairman and members of the Subcommittee, I am pleased to be here today to discuss the progress, challenges, and future direction of health care at the Roudebush VA Medical Center in Indianapolis, Indiana.

The Indianapolis VA Medical Center has been proudly serving Indiana Veterans since 1932. The present medical center, located on the campus of the Indiana University School of Medicine campus, opened in 1952. In 1982, by an Act of Congress, the two-division facility was renamed the Richard L. Roudebush VA Medical Center, after a notable legislator and former Administrator of the then Veterans Administration. The facility has been upgraded numerous times to keep pace with advances in medical care, education and research. Two increments of major construction in the last decade doubled the square footage in the medical center and permitted consolidation of a two-division facility to provide better medical backup and efficiency in the care of veterans.
As the Indianapolis Medical Center is VA's tertiary care facility in the state of Indiana, referrals from the Northern Indiana Healthcare System and the Illiana Healthcare System at Danville, Illinois are common and add to the important role of the medical center for veteran specialty medical and surgical care. Furthermore, the medical center accepts referrals from facilities in neighboring VA networks especially in Illinois, Kentucky and Ohio. In addition to providing primary care, specialty care, extended care, and referral services, the medical center also provides an environment that promotes medical

education and training, research, and DOD services in support of current and former military service members.

The medical center has a primary service area of 33 Indiana counties containing over 292,000 veterans; 108,000 of whom are over 65 years of age. This facility provides acute inpatient medical, surgical, psychiatric, neurological, and rehabilitation care, as well as both primary and specialized outpatient services. Some noteworthy specialized services include comprehensive cardiac care, a comprehensive surgical program including open-heart and orthopedic surgery, radiation oncology treatment and community-based extended care. Serving over 38,000 patients annually, the medical center has over 350,000 outpatient visits on an annual basis and over 6,000 inpatient episodes of care.

The center is committed to delivering quality care and offers extensive research and training programs. With annual grant support exceeding $7.5 million, Indianapolis VA investigators are conducting scientific research in such areas as cardiology, diabetes, alcoholism, AIDS, Alzheimer's disease, Hepatitis, pulmonary diseases, and cancer. The VA has educational affiliations with the Indiana University Schools of Medicine, Dentistry, Nursing and Allied Health. In addition, there are educational arrangements with six other universities in the states of Indiana and Kentucky. Through these educational programs, the medical center provides clinical and administrative training opportunities for over 1,300 students each year. At any time, one hundred post-graduate physician residents and fellows are pursuing clinical training in the Indianapolis VA medical center and delivering veteran care under the supervision of VA physicians who are concurrently faculty of the Indiana University School of Medicine. This supervised clinical experience for licensed physicians is offered in 22 accredited medical specialties. The Medical Center has nine sharing agreements with the Department of Defense and plays a key role in disaster preparedness as a federal designated coordinating center for the National Disaster Medical System. Further, the Indianapolis VA Medical center provides outpatient diagnosis and treatment to active military service members and their dependents under a TriCare arrangement in cooperation with DoD. Physical examinations are provided to Army Reservists and National Guard troops under a mutually beneficial contract.

The Roudebush VA Medical Center is fully accredited by the Joint Commission on Accreditation of Healthcare Organizations in the Hospital Accreditation, Home Health Care, and Behavioral Health Care Programs. We are also fully accredited by the College of American Pathologists, the Commission on Accreditation of Rehabilitation Facilities, the Nuclear Regulatory Commission and are a certified Comprehensive Cancer Treatment Facility. All recommendations from accreditation surveys have action plans that will ensure the medical center meets all standards associated with quality patient care.

A regularly scheduled Combined Assessment Program (CAP) review by some two-dozen staff of the Office of Inspector General (OIG) was conducted at the Roudebush VA Medical Center in January 2000. The survey found no untoward circumstances significantly effecting management practices of quality of care. The recommendations have been reviewed and acted upon as outlined in the final report.

The medical center has experienced remarkable growth in recent years. Recognizing that the growth in patients served and outpatient visits will be sustained, we have undertaken several activities designed to improve patient waits and delays. More than doubling outpatient visits in the last nine years has caused a strain on the physical plant. We have little more than one exam room per provider. Given the recommended standard of at least two exam rooms per provider, we have almost completed a renovation of existing space that attempts to maximize the utilization of available square footage. While an improvement, this action is still not adequate. Indianapolis has submitted and received approval for the design and construction of additional 10,000 square feet of ambulatory care space. This action will more closely approach the standard of two exam rooms per provider.

System revisions have also been undertaken to improve the clinic waiting times. The Roudebush VA Medical Center is unique in the VA in initiating implementation of a commercial off-the-shelf software package for the scheduling of outpatient clinic appointments. Staff members have developed an interface with existing VA software to produce early results of a 30% reduction in clinic waiting times. As implementation is rolled out to all clinics, similar results are expected. Furthermore, the medical center is in the process of implementing the open access model of care as developed by the

Institute for Healthcare Improvement. This model enhances continuity of care by permitting patients to see their primary care provider, even on an urgent basis. This improves care and reduces clinic waiting times. Further work is needed in many clinic areas and is an ongoing process.

The Roudebush VA Medical Center contracts with private providers for the operation of two community based outpatient clinics (CBOCs). The CBOC located in Terre Haute, Indiana is the more mature operation and has over 5,000 veterans enrolled for care and has served over 4,000 on an annual basis. The CBOC in Bloomington, Indiana has been open slightly more than one year and serves almost 2,000 veterans. Both CBOCs are monitored for compliance with contract provisions that include electronic medical records, access, patient satisfaction, and quality of care monitors.

The Indianapolis VA Medical Center has been a leader in the area of medical care cost recovery (MCCR) collections of co-payments and third party insurance coverage. Over $11 million in collections is expected this fiscal year. This represents 6.6% of our annual operating budget. Indianapolis ranks 10th VA-wide in terms of total dollars collected. The efficiency of the billing and collection process is noteworthy when monitored by both VA and private-sector performance measures. The MCCR staff collects on average $650,000 per FTE. Furthermore, the medical center has reached an agreement with Anthem Blue Cross Blue Shield of Indiana, which will yield higher collections as well as reimbursement for back claims.

The Roudebush VA Medical Center enjoys a cooperative relationship with the VA Regional Office, Veterans Benefits Administration, located in downtown Indianapolis. The medical center receives about 260 veterans' compensation and pension (C&P) exam requests each month. More than 99% of the transmissions between Regional Office and the medical center are completed electronically. Completed C&P exam reports are stored in the electronic medical record and are available not only to Regional Office staff, but also to clinicians providing ongoing healthcare to the veteran. While the Compensation and Pension (C&P) examination turnaround time exceeded 45 days in recent months, we have isolated the problem. Approximately 25% of all exam requests include an audiology exam. While current waiting times for veterans needing an appointment in audiology clinic have decreased 50% in this fiscal year, veterans

requiring a C&P audiology exam are scheduled 120 days in the future. This aspect of the evaluation will be improved through our new scheduling system in combination with contracted services. Our turn around time for all other exams is 31 days.

The Roudebush VA Medical Center provides veteran health care across the continuum. From preventive to acute to chronic care, the medical center utilizes modern technology, compassionate, qualified staff, and a variety of healthcare venues to ensure that patient healthcare needs can be met. Provision of community based extended care has undergone change over the past few years. While we continue to use community nursing homes to provide institutional care for veterans near their homes, the Indianapolis VA Medical Center has developed the network's largest and most active home care program. We typically provide VA-paid care for more than 200 veterans in their homes at any given time, and we have realized a 66 percent reduction in institutional bed days of care for patients enrolled in our traditional homecare visit program. In addition, we are pursuing the use of telemedicine technology to maintain more available monitoring and communication with veterans and their families who prefer home care and for whom it is clinically appropriate.

Currently, the medical center uses a multi-disciplinary clinical team in the extended care screening process. The team receives referrals from medical center providers and uses clinical and social indicators to determine the most appropriate location and type of care. The screening committee considers inpatient status here and elsewhere. Veterans seen only in the outpatient venue are also considered for placement and may be enrolled in our extensive home care operation.

The Indianapolis Medical Center provides acute and ongoing mental health treatment to veterans in a variety of settings. We will implement mental health service in both of our community-based outpatient clinics by the end of this fiscal year utilizing a psychiatric clinical nurse specialist. As an alternative to repeat hospitalizations, Indianapolis established a contract Psychiatric Residential Rehabilitation Treatment Program (PRRTP) last year. In the first nine months of operation, 29 patients were admitted to the PRRTP. We have applied for CARF accreditation for the Homeless Team and Vocational Rehabilitation by the end of 2001. Our Homeless Team and Vocational Rehabilitation staff is co-located with a community partner increasing access

and support to mentally ill veterans. Psychiatry service participates in the city's PAIR Project (Psychiatric Assertive Identification and Referral Project). PAIR works to identify people in jail (prior to trial) with a psychiatric disorder, and get them into appropriate treatment.

I will be pleased to more fully develop information and programs cited in this statement or to address other matters of interest to the Sub-committee.

Testimony of

Jeffrey M. Alger

Director, Veterans Affairs Regional Office

Indianapolis, Indiana

Service Delivery Network (SDN) 2

Veterans Benefits Administration

Department of Veterans Affairs

Before the

Subcommittee on Oversight and Investigations

Committee on Veterans' Affairs

U.S. House of Representatives

September 5, 2001

Mr. Chairman and members of the Subcommittee, I have been invited to attend today's hearing to discuss the current situation and future challenges of the Compensation and Pension program at the Indianapolis VA Regional Office. The managers and line employees at the Regional Office are dedicated to providing world-class service to Indiana's veterans and their dependents. The Indianapolis VA Regional Office is located in the Minton-Capehart Federal Building, where the majority of our employees are based. In addition to that location, we have outbased employees providing services, either itinerant or full time, at the VA Medical Centers in Indianapolis, Marion, and Fort Wayne. We also provide counseling assistance at the Hoosier Veterans Assistance Foundation in Indianapolis (HVAF), which offers services to homeless and indigent veterans and their families. We have established a full-time outbased employee presence at the HVAF. Our Assistant Director, Jack McCoy, is on the Foundation's Board of Directors, in a volunteer capacity. The Foundation currently occupies a VA-owned property and we are working closely with them to obtain a funding grant so that they may be able to purchase said property for a permanent base of operations. Collocated at the Regional Office are: the staff's of the Indiana Regional Counsel's office; the newly established Memorial Service

Network office for the Midwest region; and service organization representatives of the Disabled American Veterans, American Legion, Veterans of Foreign Wars, AMVETS, Military Order of the Purple Heart, and Paralyzed Veterans of America.

The Regional Office is charged with providing service to the entire state of Indiana. There are approximately 573,000 veterans living in Indiana. We are currently paying benefits, in active claims, to about 52,000 veterans and dependents living in Indiana. Of this number, approximately 38,000 are claimants receiving benefits for service-connected disabilities. We are paying out over $26.5 million per month, with an annual benefits outlay of approximately $318 million. Our Service Center makes over 30,000 decisions on claims per year, conducts over 14,500 personal interviews per year, and handles about 104,000 telephone inquiries per year. During the past year we have established over 31,659 claims, either new or reopened. Of these, 720 were due to changes in law regarding claims for presumptive service connection of diabetes due to herbicide exposure for Vietnam Veterans and 900 due to new legislation regarding VA's duty to assist veterans in the development of their claims. Our current pending workload is at 6,900.

The VARO has been adequately funded for the past two years in support of our employment, travel, and other needs. We have an annual budget of over $8.7 million. In addition, in FY 2001, we utilized $1.3 million to provide contract counseling services in the state through our Vocational Rehabilitation and Employment Services.

To deal with our increased pending workload we have adopted a number of suggestions proposed by the Veterans Benefits Administration's (VBA's) Office of Field Operations. These include: a slowdown on the activation of VBA's Rating Board Automation (RBA) 2000 initiative, a software program that assists in rating preparation (all new Rating Specialists utilize RBA 2000 in all their cases; however, long-time Rating Specialists may use regular RBA for cases that are not already established in RBA 2000); some specialization (we are using newer Veteran Services Representatives (VSR's) to answer telephone inquiries and we have continued our efforts to have a team specialize in

processing appeals); we are authorizing overtime for our decision makers to work each weekend; we are authorizing employees to cancel leave plans and have their excess leave balances carried forward at the end of the year; and our Decision Review Officers are participating in rating cases in addition to their appellate work, especially on authorized overtime. We have recently hired a number of new trainee Rating Veteran Service Representative's (RVSR's) and VSR's who are utilizing their new knowledge to assist in controlling and developing cases, especially in inputting information to our inventory management system. In addition, we are working closely with our local service organization representatives to fully utilize our case management activities that allow telephone development and follow up in acquiring needed information from veterans to continue processing of their claims.

We are proud of our Balanced Scorecard accomplishments for this year. The Balanced Scorecard is a method by which VBA measures outcomes in five broad categories: Speed; Accuracy; Unit Cost; Customer Satisfaction; and Employee Development and Satisfaction. Within each broad category are specific functions or actions used to measure station performance. Outcomes in each category continue to equal or exceed the national averages for the current fiscal year through the end of July. In Rating Related end products completed we are at 155.2 days, as compared to the national average of 176.5 days. Our Rating Related pending workload is at 133.2 days, in comparison to the national average of 172.3 days. In Non-Rating Related end products completed, our average number of days to complete is 27.2 days, compared to the national average of 50.9 days, and our pending workload is at 74.6 days compared to the national average of 114.3 days. Our appeals resolution time continues to be one of the best in the nation at 462 days, compared to the national average of 597.4 days. Our quality scores, which are accumulated by VBA's Service Delivery Network (SDN), almost mirror the national scores. We have a score of 71.6 in Rating work, which is exactly the same as the national score. In Authorization, our score is 57.2, versus a national score of 59.1 percent. In the Fiduciary unit, our score is 68.2 percent versus a national score of 65.9 percent. Continued training and focus on error trends is helping our scores to gradually improve

through the year. We anticipate that we will meet or exceed all our accuracy goals for this fiscal year. In telephone activities, we are among the best in the nation in our ratio of abandoned (2.2%) and blocked calls (0.2%). Indianapolis is one of the pilot sites for establishment of a Virtual Information Center (VIC) for answering telephone calls. The VIC is an initiative in SDN 2 whereby we utilize all stations to answer telephone calls incoming from anywhere in the SDN. For example, if a Hoosier veteran calls the Indianapolis Regional Office on our toll-free line and all of our lines are busy, the veteran's call will automatically be transferred to an available line anywhere in the SDN. This transfer is automatic. Our data information system allows any VSR in the SDN to access claim information for other stations in the SDN. Therefore, VSR's are able to answer veteran's inquiries in a majority of the cases.

Three VA Medical Centers (VAMC's) handle our requests for processing Compensation and Pension examinations. These are the Roudebush VAMC in Indianapolis, Northern Indiana Health Care System (NIHCS), and Louisville, Kentucky. The majority of our exam requests are submitted to the Roudebush VAMC. Current exam timeliness (end of month-July) for each VAMC is as follows: Indianapolis = 53 days; NIHCS = 41.9 days; and Louisville = 32.8 days. Our Service Center Manager and his staff meet with the C&P exam unit staff at each medical center on a quarterly basis to discuss pending workload, problem areas and other areas of concern. Our three servicing VAMC's have been very cooperative in assisting us to meet our goals of prompt and quality service to our veterans.

Other areas of cooperation, under the One-VA umbrella, between our office and the Veterans Health Administration include: my service on the newly formed VISN 11 CARES task force; my ad hoc membership in the VISN 11 Management Assistance Council, including attendance at annual Stakeholder advisory meetings; exploration of the feasibility of VA Medical Centers processing applications for, and payments of annual clothing allowances, with VARO employees providing training to VAMC employees; an employee Alternative Dispute Resolution (ADR) process that is integrated with and supported by the Roudebush VAMC ADR team and their staff; and attendance

by a member of the Roudebush VAMC management staff at the Regional Office director's staff meetings.

VBA national initiatives continue to be successfully implemented at the Indianapolis Regional Office. Case Management has been underway at our office since June 2000; this continues to assist us in improving in the development of claims along with improved customer satisfaction. Our conversion to the Business Process Reengineering model of teams has been successful. We are in the process of expanding our number of teams, from four to five, by adding an additional claims processing team to adjust for our increased staffing. We recently advertised two Coach positions to accommodate the increased number of teams and to lessen the span of control for one of the coaches. The Coach position, relatively new to VBA, a Coach is considered to be a team leader who is responsible for scheduling workload and leading the team towards its goals. The new Coaches have been selected and will start with their new teams on October 1, 2001.

Nineteen percent of our current workforce will be eligible for retirement in the next three years. We were authorized an increase in our FTEE during the past year from 145, to a ceiling of 161. We have completed all hiring, to include three new Rating Specialists. All newly-hired employees are in the midst of their centralized training program and are fully utilizing available modules of the computer assisted training program, called the Training and Performance Support System (TPSS). All accredited Service Organization representatives have been trained by VARO personnel in the Training, Responsibility, Involvement, and Preparation (TRIP) initiative. This initiative was formulated so that we can more fully utilize the expertise and time of the Service Officers to assist us in the development of cases and so that they will provide a more complete application package from the outset. We have hired an additional Decision Review Officer (DRO) to bring our total to three. All DRO's work closely with the Service Officers to ensure that veterans are taking full advantage of having their cases reviewed under the *de novo* review authority outlined in the regulations creating the DRO program.

This completes my formal presentation to the Subcommittee. I will be happy to answer any questions.

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Congressional Testimony

STATEMENT BY

FREDERICK G. BITNER

LOCAL PRESIDENT
OF THE
AMERICAN FEDERATION OF GOVERNMENT EMPLOYEES, AFL-CIO
LOCAL 610

TO

HOUSE COMMITTEE ON VETERANS' AFFIARS
OVERSIGHT SUBCOMMITTEE

AT THE INDIANAPOLIS, INDIANA FIELD HEARING

ON MANAGEMENT AND DELEIVERY OF BENEFITS
AT THE
VETERANS' BENEFITS ADMINISTRATION
INDIANAPOLIS REGIONAL OFFICE

SEPTEMBER 5, 2001

American Federation of Government Employees, AFL-CIO
80 F Street, NW. Washington, D.C. 20001 ★ (202) 737-8700 ★ www.afge.org

Chairman Buyer and Representative Carson, my name is Frederick G. Bitner. I am the President of the American Federation of Government Employees (AFGE) Local 610 and I am a service-connected disabled veteran. AFGE Local 610 is proud to represent 131 workers at the Indianapolis Regional Office of the Veterans' Benefits Administration (VBA). The men and women AFGE Local 610 represents care deeply about providing benefits and services to veterans and their families. The employees at the Indianapolis VBA Regional Office want to provide veterans and their families with responsive, timely and compassionate service.

We applaud you for holding this oversight hearing and appreciate the opportunity to share with you the perspective of the front-line workforce on how Congress and VBA can improve the delivery of benefits to veterans and their families.

In the past several years a confluence of three trends has made work at the VBA more chaotic and difficult.

First, the nature of compensation and pension (or C&P) adjudication has grown increasingly complex and legalistic. Preparing or rating a compensation claim requires the ability to review and evaluate technical medical information by complex legal standards of proof. For example, claims dealing with Gulf War Syndrome and Agent Orange exposure often deal with issues of statistical risk and exposure rates. These claims are a very different from than the claims dealt with for most WWII veterans.

Second, at the same time that the presumptions involved with claims and establishment of claims have become more complex and legalistic, management has responded with new initiatives, shifts in philosophy, transformations in priorities, new benchmarks, and new computer programs. While each initiative du jour may have merit, in aggregate they create a constant state of reorganization and revamping of processes. This reduces our effectiveness. The constant and chaotic state of change is hard on employees. It distracts us from "the prize" — to provide veterans with responsive and quality service.

Third, our workforce is changing. In anticipation of the nearing retirement of more and more VBA claims examiners, VBA has begun to hire new staff. This means that at our office we have a group of employees who are very seasoned and experienced, and a group of Veterans Service Representatives who are still learning many of the basics of C&P.

What can be done systemically to respond to these trends?

AFGE Local 610 urges continued support for training. VBA employees need recurring training. Whenever Congress establishes or modifies new presumptions we need training to ensure that veterans receive consistent and

fair claims development and adjudication under these new or modified standards. Whenever case law significantly alters processes or standards of proof we need training. Currently, such training is not the norm.

VBA has now instituted centralized training for newly hired Veterans Service Representatives (commonly referred to as claims examiners.) However, there is a significant number of employees who where hired in the past two years who are not included in this training. Employees hired one year ago are mentored by a experienced examiner but do not receive the centralized training. These "mentored" employees need equivalent training and all employees need recurring training as new presumptions are established or standards of proof are modified.

I can't emphasize enough how important proper training and recurring training is to ensure the timely and accurate processing of veterans' claims. One AFGE Local 610 member, who is a newer employee, told me that she cringes when she thinks about how her lack of training might result in mistakes that impact on our clients.

AFGE 610 also believes that the grade-level for Rating Veterans Service Representatives, or rating specialists, should be revisited. The job has been a General Schedule 12 (GS-12) for at least 30 years. Rating a veterans disability claim has gotten more technical, complicated and legalistic. If we are to retain experienced ratings specialists and provide a career ladder for new claims examiners we must recognize that a rating specialist is more on par with a GS-13. Chairman Buyer and Representative Carson, I urge you to press VBA to approach the Office of Personnel Management to raise the grade level of Rating Veterans Service Representatives.

AFGE Local 610 also urges you to continue oversight of VBA's use of centralized processing of claims. We are concerned that veterans may feel alienated when they cannot visit a local office to meet with a claims examiner to discuss their case.

I thank you for the opportunity to submit testimony.

STATEMENT OF

OF

TERI L. JAMES, RN
LOCAL PRESIDENT
AMERICAN FEDERATION OF GOVERNMENT EMPLOYEES, AFL-CIO
LOCAL 609

BEFORE

THE HOUSE COMMITTEE ON VETERANS' AFFAIRS
OVERSIGHT AND INVESTIGATIONS SUBCOMMITTEE

INDIANAPOLIS, INDIANA FIELD HEARING
ON

MANAGEMENT AND QUALITY OF CARE AT THE
RICHARD L. ROUDEBUSH VA MEDICAL CENTER

SEPTEMBER 5, 2001

Chairman Buyer and Ranking Member Carson, my name is Teri L. James. I am President of Local 609 of the American Federation of Government Employees (AFGE). My union represents professional health care workers at the Richard L. Roudebush VA Medical Center in Indianapolis, IN. Nationwide, AFGE represents 135,000 VA employees.

I have proudly worked as a Registered Nurse (RN) at the Richard L. Roudebush VA Medical Center for ten years. Before that I was a RN at the Marion, Indiana, VA facility for 13 years. Both my parents were RNs at VA facilities and my grandfather was a Nursing Assistant at the Marion VA facility. My nursing career has been dedicated to caring for veterans.

Understaffing is Threatening patient Care and Safety

The lack of adequate staffing at the Richard L. Roudebush VAMC is of paramount concern for the health care providers that AFGE represents. Because these health care providers are first and foremost patients' advocates, they are concerned about how veterans suffer and patient safety is jeopardized due to inadequate staffing.

The lack of nursing staff at the VA – nationwide, in our state and in our facility – is devastating.

From September 1995 to September 2000, nationwide VA cut Registered Nurses (RNs) by 10 percent, Licensed Practical Nurses (LPNs) by 13 percent, and Nursing Assistants (NAs) by 30 percent. These cuts have meant a loss of 1 in 6 direct patient caregivers. At the Richard L. Roudebush facility we are "budgeted" for 371 RNs but only have 366 on staff. In reality, we need more nurses than the even the 371 positions VA management has budgeted for our facility.

This staffing crisis impacts the quality of care veterans' receive and threatens patient safety. When there are not enough RNs and support staff to care for the patients, staff are more likely to make medical errors. Even when medical errors are avoided, patients still suffer. Harried and weary nurses may not be as observant of subtle changes in a patient's condition that signal a medical problem. Overwhelmed and overworked nurses may also lack the keen level of concentration and emotional stamina necessary to deliver high quality and compassionate care. Medical records, medications, basic care, and critical medical interventions are delayed, forgotten or mixed up because staff is spread too thin.

A 1998 study showed that patients who have surgery done in hospitals with fewer RNs per patient than other hospitals run a higher risk of developing avoidable complications, such as pneumonia and urinary tract infections. A 1995 of patient outcomes found that the RN-to-bed ratio was the most important factor in predicting the differences among hospitals' success rates in saving patients that experienced serious adverse events. This is because nurses are the ones who first recognize a medical complication and call the physician.

The perils of understaffing are very evident on our Medical Intensive Care Unit (or MICU). This ward is for veterans who need a high level of constant care and have severe medical conditions. This unit is supposed to operate with nine RNs on all shifts plus a staff person whose sole responsibility is to watch all the cardiac monitors. A safe staff-to-patient ratio is one RN per one or two MICU patients. Rarely does VA management meet this staffing level.

Recently, MICU had seven RN for 24 patients, or a ratio of one RN to 3.4 patients. Of these 24 patients, eight had medical conditions rated at the most extreme acuity level. These eight patients were all on respiratory ventilators. Safe staffing policy dictates one RN for each one of these patients. This is to ensure that each patient would have a dedicated nurse to monitor his or her breathing and to respond immediately a ventilator alarm. The failure to respond immediately to a ventilator patient in distress could mean the patient's death.

VA management's failure to adequately staff MICU and other units places patient safety at risk.

The lack of staff also means that veterans are being denied access to care at the VA and veterans are being diverted to private sector hospitals at what we presume is a great expense to VA facilities. The training of medical and nursing students also suffers because current staff have no time or energy to provide students with the review and feedback crucial to their education as health care professionals.

Although the nursing shortage has been highlighted in the media, other professions are on the verge of crisis of similar proportions. Unfilled pharmacists positions are rapidly on the rise, at the same time the demand for these essential health care workers is growing and enrollment in pharmacy schools is dropping. VA is also vulnerable to the growing shortage of social workers and medical technologists. We also are having difficulty recruiting and retaining physical therapists and other key therapeutic staff who are indispensable to veterans' care.

VA Management's Response to this Crisis in Staffing is Inadequate

AFGE Local 609 is very concerned that VA management is not responding adequately to this crisis in staffing.

Even though we are having significant problems in retaining and hiring staff, our facility's management has stated that they are actively avoiding recruitment and retention bonuses.

Promotions are key to retaining nursing staff. Our facility management has failed to recognize the work of experienced nurses by denying them pay promotions from Nurse I to Nurse II and from Nurse II to Nurse III. In our facility, promotions to the Nurse Level III are infrequent.

VA's new Nurse Qualification Standards are practically shutting the door on promotions to a Nurse Level II unless a nurse has a Bachelor of Nursing Science (BSN). Most licensed nurses nationwide do not have BSN but do have a diploma or associate degree. How can the VA expect to retain or recruit employees who are highly qualified, experienced, licensed RNs, who happen to choose a different course of education if it will never promote them because of their particular degree?

Competitive pay is key to both keeping nurses on staff, improving morale and in becoming the employer of choice. Recently our facility gave Nurse Level I RNs a only 3 percent pay raise, Nurse Level II RNs a 2 percent pay raise and Nurse Level III employees no raise at all.

VA employees understand that they must work on weekends because medical care for veterans is a round-the-clock, seven-days-a week operation. In the private sector employees are routinely paid a premium for working on less desirable shifts. This is not the case at the VA.

By law, RN's receive a premium for working on weekends. This premium is not for overtime but for a regular shift. Pharmacists, Physical Therapists, Respiratory Therapists and Licensed Practical Nurses, are guaranteed only Sunday premium pay. Saturday premium pay is at the option of the Medical Director. This is because in the 1980'2 Congress created a category of employee's considered "hybrid" because they straddle the personnel laws of Title 38 and Title 5 employees. Our facility's management has used its authority to deny many of these key employees Saturday premium pay.

For Title 5 employees, like medical technologists and nursing assistants, the law prohibits them from being paid premium pay for working a regular shift on Saturdays. For these employees the law only provides them with Sunday premium pay.

Chairman Buyer and Representative Carson, I urge you to support changing the law to ensure that all VA employees who work on Saturdays receive Saturday premium pay.

In addition to pay, there are other important intangibles – like professional respect and including staff in key policy and staffing decisions – that VA management must improve.

When VA fails to create favorable working conditions by treating its staff with respect and dignity it sends a profound message to not only its workforce but to candidates for employment. Moreover, the way that VA management treats its workforce ultimately redounds to DVA's genuine desire and capability to honor veterans with compassionate and high quality care.

Chairman Buyer and Representative Carson, I thank you for holding this oversight hearing. Thank concludes my testimony.

STATEMENT SUBMITTED BY

BILL OVERBEY

LOCAL PRESIDENT
AMERICAN FEDERATION OF GOVERNMENT EMPLOYEES, AFL-CIO
LOCAL 1020

TO

THE HOUSE VETERANS' AFFAIRS COMMITTEE
OVERSIGHT AND INVESTIGATIONS SUBCOMMITTE

AT THE INDIANAPOLIS, INDIANA, FIELD HEARING

ON QUALITY OF CARE AND MANAGEMENT ISSUES IN INDIANA

SEPTEMBER 5, 2001

Chairman Buyer and Representative Carson, my name is Bill Overbey. I am the Local President of the American Federation of Government Employees (AFGE) Local 1020, which represents the employees at the Marion, IN, campus of the VA Northern Indiana Health Care System (VA NIHCS). My Local represents the full range of health care workers and support staff at this facility. AFGE Local 1020 appreciates the opportunity to update you on the changes affecting our ability to provide veterans with quality care.

The Elimination of Inpatient Beds Denies Veterans Access to Needed Care

Our Veterans Service Integrated Network (or VISN) budget is adequate. An expected multi-million dollar shortfall is driving patient care decisions. This is not in the best interest of veterans.

Management is proposing to decrease our inpatient psychiatry care by at least 50 beds. This will involve discharging 50 veterans in need of psychiatric care, including those who need the protective environment of a restricted ward. The restrictive ward or locked unit is a part of the brand new inpatient building VA NIHCS opened a year ago and cost approximately $20 million to construct.

VISN 11 management is ordering VA NIHCS to discharge 25 patients and close a unit no later than September 15, 2001. We will be required to discharge another 25 patients and close another psychiatric unit no later than December 1, 2001. Once these psychiatric care units are closed we will be shutting the doors on veterans who desperately need this care.

Whether to discharge a psychiatric patient and, if so, when are important medical decisions. By ordering the closure of these essential treatment beds, VISN 11 and the VA NIHCS management are in effect pressuring and pushing for a specific course of medical treatment and discharge plan for individual patients to suit their timelines not the needs of the veterans.

AFGE Local 1020 is very troubled by the closing of these beds as we believe it is not based on sound medical practice or policy. The discharges to other facilities, or to the street are to take place regardless of the treatment team assessment of what is in the best interest of the patient. The sole purpose of this action is to save money for the VISN by closing two inpatient psychiatric units. Ultimately this will decrease staff levels by decreasing the overall inpatient caseload as well. Our VA facility will deny veterans access to health care with the excuse that we don't have any available beds.

Will VISN 11 or VA NIHCS management be held accountable for any negative outcome to our patients because they are being discharged against the professional opinion of the treating physician? Instead, it is more likely, that if a patient commits suicide or is otherwise negatively affected as a result of this

forced discharge that the treating physician will be held legally and ethically accountable.

Chairman Buyer and Representative Carson, AFGE Local 1020 urges you to help stop the closure of these psychiatric beds.

VA NIHCS management has also determined that our acute medical care unit should be "consolidated." This is a misnomer as beds are being eliminated not moved elsewhere. Our VA sister facility in Fort Wayne will not have a single additional medical unit bed. Nor will the VA Fort Wayne facility receive any additional medical staff as a result of this "consolidation".

The elimination of this medical care unit will cost veterans access to care. It will also increase our costs for transporting veterans back and forth from community hospitals (both in Marion and surrounding communities), nursing home facilities and to other VA facilities in Fort Wayne and Indianapolis.

The closure of this medical unit will adversely impact veterans who need a range of care. This unit provides acute medical care for outpatients who need inpatient care but for less than a full 24 hours. This unit also provides care for homeless veterans and patients with alcohol and polysubstance abuse and dependence problems. This unit also provides respite care for chronic care patients.

Closing the acute medical care beds will not make homeless or addicted veterans in need of medical care disappear. It will mean the VA is shutting its doors on veterans in need. It means VA will shunt veterans to contractors. It means VA will abdicate and relinquish its direct care for these sicker, older and poorer veterans.

The acute medical care unit should not be closed.

Inadequate Staffing Levels Threaten Quality of Care

In June 1, 2001, this subcommittee held a hearing in Marion, Indiana, and I testified about how inadequate staffing was placing care at risk. Since that hearing the VA NICHS received supplemental funding for FY 2000. Unfortunately, this money was not used to improve staffing levels. The staffing numbers at VA NIHCS have remained basically the same. The status quo is unacceptable and threatens the quality of care our facility can deliver to veterans.

Retention and recruitment of VA health care providers are in need of improvement. We need adequate numbers of well-trained staff to manage workloads, to prevent harmful delays in care, to avert medical errors and to improve services.

Currently, there is a mounting nursing shortage across the nation. Congress must act now to ensure that VA can retain and recruit adequate numbers of Registered Nurses, Licensed Practical Nurses and Nursing Assistants. The staffing problem is likely to get worse as nurses' and the veterans they care for grow older. VA patients are already older, sicker and poorer than the non-VA patient population treated in the private sector. Although the overall veteran population will decrease in the coming decades, the demand on the VA for the most labor intensive medical care for elderly veterans with chronic and multiple illnesses, and disabling conditions will increase.

The increase in demand will occur when VA's workforce is approaching retirement at a faster rate then the nursing workforce in the private sector. According to the American Hospital Association, the average age of nurses providing inpatient care is 45; in the VA the average age for a full time RN is 48. Within four years 35% of VA's RNs will be eligible to retire. At the same time, 29% of the LPNs and 34% of the NAs will be eligible to retire. VA will not be able to provide care for the most vulnerable veterans – the poor, elderly and disabled – when they are most in need of VA's care, unless we act expeditiously.

The Senate Veterans Affairs Committee has approved S. 1188, the Department of Veterans Affairs Nurse Recruitment and Retention Enhancement Act of 2001. This legislation takes important steps to address the staffing shortage at VA. It is expected that the full Senate will vote on this legislation later this month. AFGE asks for your support of S. 1188 when the House Veterans' Affairs Committee considers this legislation.

Although the nursing shortage has been most visible in the media, other professions are on the verge of crisis of similar proportions. Unfilled pharmacists positions are rapidly growing, at the same time the demand for pharmacists is increasing and enrollment in pharmacy schools are decreasing. VA is particularly vulnerable to this emerging shortage because nearly a third of VA's pharmacists are 50 years or older and moving towards retirement. The VA is also vulnerable to the growing shortage of social workers because it is the single largest employer of social workers in the nation. These professionals are key to treating VA's older, sicker and poorer patient population. VA must act now to replace the 1 in 8 social workers it has lost since 1995.

As with the nursing shortage, we must heed the warning signs in the current working conditions for pharmacists, social workers and other essential direct and adjunct health care occupations while we address supply issues.

This concludes my statement. Thank you again for the opportunity to testify.

WRITTEN COMMITTEE QUESTIONS AND THEIR RESPONSES

Post-Hearing Questions
Regarding the September 5, 2001, Field Hearing
For the Honorable Anthony Principi
Secretary, Department of Veterans Affairs

From The Honorable Julia Carson
Subcommittee on Oversight and Investigations
Committee on Veterans' Affairs
United States House of Representatives

Question 1: Explain the roles of stakeholder involvement and cost/benefit analysis in your fifth vision – that the VA must use sound business principles to accomplish its mission?

Response: The application of sound business principles is a core component of the *enabling goal*. It is my aim to apply sound business principles throughout the organization and hold my managers accountable. These principles include cost/benefit analysis, capital investment planning, information technology enterprise architecture planning, workforce planning, competitive sourcing, and numerous other tools that incorporate sound business principles. Cost/benefit analysis is an especially useful tool for the evaluation of health care and other service delivery alternatives.

The Department considers stakeholder input essential to the decision-making process. We have a number of inter-agency efforts underway in many areas of our health care and benefit programs. In the context of our strategic planning process, we have assembled a stakeholder group that we call *Four Corners*. This group is composed of VA leadership, staff from our Congressional authorizing and appropriation committees, Office of Management and Budget staff, and representatives from the major Veterans Service Organizations. This group was fully involved during the development of our current strategic plan reviewing and discussing the plan at several *Four Corners* meetings. This group also discusses various policy issues important to improving service to veterans and their families. We are also in the process of conducting focus groups with veterans around the country asking for their input on VA issues. Improving sound business principles and involving stakeholders in everything we do will help us provide better programs and services to veterans and their families.

Page 2.

Question 2: Is vision/goal 5 the most important of VA's five goals?

Response: While this goal is an important part of my vision, I would not say that it is the most important of VA's five goals. Our mission to ""To care for him who has borne the battle, and for his widow and his orphan" is clear. All five of the strategic goals are an integral part of my vision to provide our Nation's veterans with the best benefits and services we can. The *enabling goal* is our management goal and it challenges the organization to achieve excellence in administrative and managerial support to the Department and the application of sound business principles is an integral part of that support. It also stresses the importance of communication, workforce, information technology, and overall *governance*.

We cannot keep our promise to veterans unless we achieve excellent results in each of these goal areas, and this is especially the case for the four strategic goals. VA's application of sound business principles and the *enabling goal* simply support the achievement of these strategic goals.

Question 3. What is the purpose of the Capital Asset Realignment for Enhanced Services (CARES) review?

Response: In 1999, a General Accounting Office report concluded that the Veterans Health Administration (VHA) could significantly reduce the funds used to operate and maintain its capital infrastructure by developing and implementing market-based plans for restructuring assets. In response to this and Congressional hearings, VA developed the CARES review process.

The purpose of the CARES program is to assess veteran health care needs in VHA networks, identify service delivery options to meet those needs in the future, and guide the realignment and allocation of capital assets to support the delivery of health care services.

The Phase I pilot began in January 2001 in VISN 12, which included seven VA health care systems in northern Illinois, parts of Michigan, and Wisconsin. The 60-day public comment period about the service delivery options developed by the CARES contractor, Booz-Allen & Hamilton, ended mid-September. We will be making final decisions soon about which short and long-term options best meet veteran health care needs in VISN 12. In subsequent phases, the CARES process will review each of VHA's 22 VISNs.

DEPARTMENT OF VETERANS AFFAIRS
INSPECTOR GENERAL
WASHINGTON DC 20420

SEP 27 2001

Honorable Julia Carson
Ranking Member
US House of Representatives
Committee on Veterans' Affairs
Subcommittee on Oversight and Investigations
333 Cannon House Office Building
Washington, DC 20515

Dear Mrs. Carson:

This responds to your September 10, 2001 letter presenting questions about issues stemming from my office's Combined Assessment Program (CAP) reviews at the Northern Indiana Health Care System in Marion and Ft Wayne, IN, and the Richard J. Roudebush VA Medical Center in Indianapolis, IN. The questions were in follow up to the September 5 field hearing that the Subcommittee held in Indianapolis.

I have enclosed my responses to your questions with this letter. If my staff or I can be of any further assistance to you in this matter, please call me at (202) 565-8620.

Sincerely,

RICHARD J. GRIFFIN

Enclosure

September 26, 2001

White Paper
Questions from Ranking Democratic Member, The Honorable Julia Carson

Question:

The IG closed its official follow-up of the May 25, 2000 CAP review of the VA Northern Indiana Health Care System (NIHCS) on August 31, 2001. Did the IG receive and review Veterans Integrated Service Network (VISN) 11 or NIHCS-initiated "comprehensive reviews" of the:

a. Sub-Acute Rehabilitation Program Unit move to Fort Wayne?

Answer: We received and reviewed VHA's comprehensive assessment of the Sub-Acute Rehabilitation Program and long-term consolidation issues at the NIHCS. The Director, NIHCS sought outside assistance in determining whether to move the sub-acute rehabilitation unit to Fort Wayne. He arranged for Dr. Andrea Conti-Wyneken, a faculty member at the Indiana University School of Medicine, and Chief Pulmonary Medicine and Rehabilitation Service (PM&RS) at VAMC Indianapolis, who was accompanied by a CARF surveyor, to visit the NIHCS and review the program. They determined that the physical plant and human resources existed to support vital rehabilitation service to the veterans in Ft. Wayne, Marion, and surrounding communities. Dr. Conti-Wyneken and the CARF surveyor believed that it was reasonable to realign rehabilitation services to better serve acute inpatients, extended care patients and outpatients at the Ft. Wayne campus and maintain sub-acute interdisciplinary rehabilitation, psychiatric and outpatient services at the Marion campus. We agreed with the concept if the Director agreed to implement Dr. Conti-Wyneken's and the CARF surveyor's suggestions. He informed us he would implement the suggestions.

Although the managers at both facilities demonstrated commitment to rehabilitation therapies and adjunct resources, there has not been consistent clinical input and leadership since the retirement of the NIHCS' Chief of PM&RS in June 2000. The workload and patient population served would support the work of a full time PM&R Specialist to complete consultative services for the rehabilitation needs of patients on both campuses in the acute medical and surgical area, the extended care area, and the outpatient area. Dr. Conti-Wyneken and the CARF surveyor believed this could be done initially through contract consultants; however, a fulltime position would be optimal. Dr. Conti-Wyneken confirmed that practices and policies were not consistent between the two campuses and indeed, there was little sharing of resources, and a sense of division made greater by the geographical distance between the two facilities. Dr. Conti-Wyneken suggested a single supervisor of therapies for the entire PM&RS. She also suggested the Director ensure more frequent formal meetings that include the therapy supervisors and lead therapists and the physician chief of the services to

maintain open communication of service goals and expectations and to address problems as they arise. Suggestions were also made to identify the appropriate continuum of care and to move patients more readily in order to utilize the staff and resources most efficiently at both campuses. The Director informed us that he is recruiting a full-time physiatrist and working on implementing VHA reviewers' findings and conclusions. The VISN is keenly aware of the emphasis in ensuring this issue is resolved to the benefit of the patient population.

b. Long-term care consolidation at Marion, VA facility?

Answer: We received and reviewed the comprehensive review by the Health Systems Research and Development (HSR&D) Service's, Management Division and Research Center (MDRC). MDRC surveyors reviewed all Inpatient Extended Care programs at NIHCS for their potential for consolidation. The MDRC considered the options for providing nursing home care in the NIHCS, including consideration of the current use of the NHCUs at Fort Wayne and Marion, the physical plants and renovations needed to meet nursing home licensing requirements, the continuum of care at each campus, and patient and family access.

The MDRC recommended that the NIHCS convert the Fort Wayne NHCU to swing beds for short-term sub-acute care within the acute care unit. Adopting this recommendation would essentially formalize the shift away from the traditional NHCU that has already taken place at Fort Wayne, and would preclude a substantial investment in making the Fort Wayne facility compliant with nursing home care standards. In order to comply with the Millennium Bill, all NHCU beds at Fort Wayne should be transferred to Marion so that there is no net loss in NHCU beds in NIHCS.

We reviewed the results of the assessment and believed that MDRC has come up with a viable management alternative. We agreed swing beds offer managers the most flexibility in using beds between acute and sub-acute care, and in assigning staff as needed. We also agreed that a core of the original Fort Wayne NHCU staff remain dedicated to the sub-acute beds. Continuing to work together would maintain the coordinated expertise of a team that has experience working together. The shift to sub-acute beds should not have a substantial impact on Marion staff since few patients would be transferred to Marion, and there appears to be adequate capacity. As the benefits of the remodeled facility at Marion are maximized, we would expect staff caseload to grow.

While managers recognized that veterans and their families would have to choose between traveling further or electing to be transferred to nearby community nursing homes, the shift would maximize the care provided to patients, and preclude extensive renovations. The Director agreed to this course of action.

c. & d. Closure of beds in the new psychiatric facility at Marion VA? Closure of all medical beds at Marion, VA?

We have not completed our review of proposals to close psychiatric and medical beds at the VA Marion campus. The OIG received a recent request from the House Veterans Affairs Committee (HVAC), Subcommittee on Oversight and Investigations to review VISN 11 and NIHCS plans to close beds in the new psychiatric facility at the Marion facility, and all medical beds at the Marion facility. We visited the Marion campus the last week of August 2001, and learned that VISN 11 plans to retain 16 acute medical beds at the Marion facility. We are currently conducting further reviews of bed allocations and other concerns of the HVAC Subcommittee on Oversight and Investigations through September 2001.

DEPARTMENT OF VETERANS AFFAIRS
INSPECTOR GENERAL
WASHINGTON DC 20420

SEP 27

Honorable Julia Carson
Ranking Member
US House of Representatives
Committee on Veterans' Affairs
Subcommittee on Oversight and Investigations
333 Cannon House Office Building
Washington, DC 20515

Dear Mrs. Carson:

This responds to your September 10, 2001 letter to Alanson Schweitzer, Assistant Inspector General for Healthcare Inspections, presenting questions about issues stemming from my office's Combined Assessment Program (CAP) reviews at the Northern Indiana Health Care System in Marion and Ft Wayne, IN, and the Richard J. Roudebush VA Medical Center in Indianapolis, IN. The questions were in follow up to the September 5 field hearing that the Subcommittee held in Indianapolis.

I have enclosed Mr Schweitzer's responses to your questions with this letter, to be included in the hearing testimony. If my staff or I can be of any further assistance to you in this matter, please call me at (202) 565-8620.

Sincerely,

RICHARD J. GRIFFIN

Enclosure

September 26, 2001

White Paper
Response to Questions from the Honorable Julia Carson

1. Should the DVA review reports and assessments of State nursing home inspectors/investigations when determining the suitability of a nursing home for an eligible veteran?

Clinical employees at VA medical centers should review reports and assessments of State nursing home inspectors/investigations when determining the suitability of contract nursing homes (CNH) for eligible veterans. Additionally, VA Medical Center Directors should appoint CNH Evaluation Teams that provide annual evaluations of CNHs and properly skilled clinicians should provide follow-up once patients are placed in CNHs. Evaluation teams should consist of nurses, social workers, physicians, dietitians, pharmacists, fire safety officers, contracting officers, environmental management specialists, and administrative representatives. Teams should review all annual and any interim inspection findings of other agencies (i.e., State inspections, Joint Commission on the Accreditation of Healthcare Organizations inspections, etc.), and review appropriate available findings of their ombudsman or local complaint office. Additionally, teams should conduct on-site inspections of CNH facilities. All of these efforts are designed to ensure that patients receive appropriate and safe placements, and that the quality of care at CNHs is consistent with VHA standards.

Our reviews of the CNH program at VHA facilities during Combined Assessment Program (CAP) reviews, showed that some facilities did not obtain and review other Federal and State agency reports to ensure identified problems were corrected. VHA has been working on revising CNH policies and practices for over a year. Consequently, practices have differed from facility to facility. We found that once patients were placed in CNHs, VA inspection teams did not always conduct annual CNH inspections to ensure compliance with VA safety and quality standards. Annual patient physicals were not always conducted. A multidisciplinary committee to oversee the quality of care provided by the CNH programs was not always established. Medical staff did not provide input or participate in the approval of CNH contracts prior to initiation and renewal.

At VAMC Indianapolis, the CNH program had a defined process for inspecting and re-inspecting local CNHs. However, the process for multi-state contract facilities did not follow the same inspection process. In general, all inspections and CNH patient visits were conducted only during the administrative workweek, and management did not require CNHs to provide performance data pertaining to patient satisfaction, processes of care, or treatment outcomes. Employees needed to schedule patient visitations outside the normal administrative tours of duty, to include weekends and evening hours. Also, the CNH contracts needed to include a requirement for the provision of performance data on a quarterly basis.

2. *At last year's field hearing in Marion, Indiana, Mr. Buyer asked you what he framed as a "tough question." He asked for your overall assessment of the senior management at the Marion VA Medical Center. You responded, "that they're a very competent team." Your response detailed management's responsiveness to the problems the IG noted during your CAP review. What is your current assessment of senior management at the Richard Roudebush VA Medical Center, the NIHCS, and at VISN 11? Please address planning acumen, teambuilding, leadership, veterans' service, and sound business practices.*

During our on-site inspections, we found management at both facilities to be cooperative with the inspection process, forthcoming in offering information, and concerned about the issues raised during the reviews. Managers at both facilities took necessary immediate actions to correct some areas of concern. Both facilities submitted appropriate and reasonable responses to the CAP reports, to include plans of action to address our recommendations.

During our follow-up of NIHCS in October 2000, we noted that some of the plans to address issues raised during the CAP review had not been accomplished. This was discussed with NIHCS and VISN 11 Directors, and now NIHCS has completed all recommended actions.

The Richard Roudebush VA Medical Center has acquired a new Director since our visit. The Director, is currently working on implementation plans to address our recommendations. We will track these plans until all issues are appropriately resolved.

Our perceptions about VA health care facility and VISN 11 managers regarding their planning acumen, teambuilding, leadership, veterans' services and sound business practices are based on our contacts during CAP reviews, Hotlines, and in oversight discussions on their responses to Hotline complaints. In many cases, we have had ongoing dialogues with these managers. All VHA leaders in VISN 11 have been responsive to our communications about planned OIG activities in their respective facilities, and have exhibited interest in improving the quality of care and services. Their corrective action plans appear to be well thought out and coordinated, and each Director appears to be engaged in continuous teambuilding activities in order to ensure effective implementation of action plans. Veterans' service officers expressed concerns about clinic waiting times issues that we find commonly throughout the country, but VISN and medical center leaders are working with the Institute of Healthcare Improvement to ameliorate these problems. Both medical centers needed to strengthen selected internal controls to improve operations and the safeguarding of Federal funds, and these issues are both discussed in the medical centers' respective CAP reports.

At the VA Northern Indiana Health Care System (NIHCS), Ft. Wayne and Marion, Indiana, we reviewed the CNH Program, including the CNH inspection process, and overall administrative and clinical oversight of CNHs. As part of NIHCS' oversight, a social worker and nurse alternate visits monthly to track the overall care provided to VA patients in CNHs. However, despite these visits, the Resource Utilization Groupings (RUGS) --version III, review was not consistently accomplished on CNH patients. This review is used to evaluate the level of care appropriate for individual patients. Thus, NIHCS relied on un-validated CNH data for decisions on continuing monthly contract rates.

Clinical managers needed to consider requesting Performance Improvement data from CNHs on a quarterly basis, and move toward completing Resident Assessment Instruments (RAIs) for all CNH patients in order to monitor contract prices. An alternative would be to require the CNHs to submit quarterly assessments of patients along with the corresponding RUGs-III levels. Also, contractors needed to work closer with NIHCS clinicians prior to approving contracts.

VA criteria also prescribe that periodic inspections be conducted of CNHs by qualified clinical and administrative staff to ensure that those facilities meet minimum standards for care of VA nursing home patients. Employees we spoke to indicated that the CNH inspection process had changed from direct VA inspections in the past, to reviews of surveys performed by the State of Indiana. Although VA staff did make occasional, unannounced spot inspections of contract nursing home care facilities, NIHCS managers rely primarily on the state inspection reports to monitor the CNHs.

While VA criterion allows for reliance on inspections by other Government agencies, reports of such inspections are to be thoroughly reviewed by qualified VA staff to determine if they identify any conditions that warrant intervention. However, at the time of our CAP review, there was no established multi-disciplinary team, either for conducting nursing home inspections, or for reviewing reports of nursing home inspections conducted by the state. Only one VA employee, a social worker, reviewed these state reports. He relied on his judgment alone to determine whether the state inspection reports revealed conditions that warranted VA intervention.

Because there are several specialized aspects to nursing home care, we believe that such decisions need to be made collectively by a team of individuals from various clinical disciplines, e.g., nurses, physicians, therapists, and social workers. NIHCS managers needed to consider conducting unannounced CNH visits to evaluate care during times when CNH administrators are not on duty. The NIHCS Director also needed to appoint a team of qualified professional staff for reviewing, and recommending action based on, state inspection reports of contract nursing homes, and for conducting VA inspections when warranted. These issues were discussed with the Director at the time of our CAP review.

Veterans Service Office Of Tippecanoe County
629 N 6th St Lafayette, IN 47901 (765) 742-1796 Fax: (765) 420-7826 E-mail: Randy@Lat.CIOE.com
Randy Fairchild -- CVSO Jackie Helvie -- Assistant

September 18th, 2001

Democratic Staff Director
Subcommittee on Oversight and Investigations
333 Cannon House Office Building
Washington, DC 20515

This letter is response to Congresswoman Carson's letter dated September 10, 2001, requesting me to answer four follow-up questions from the September 5th, 2001 field hearing in Indianapolis, IN.

1. Yes, I feel that I am a stakeholder to any major change in Indiana when it comes to any major changes concerning our veterans when it impacts on their VA healthcare or VA benefits. I have served as the Tippecanoe County Veterans' Service Officer for the last 6 years and have served the last four years on the Indiana Counties Veterans' Service Officer Association. During this time I have served as President for two years and am now in my second year as Vice-President. I also write an article in the Lafayette Journal-Courier bi-weekly on veterans' benefits that reach approximately 28,000 veterans in a 7-county area.

I do not have any direct knowledge concerning questions 2, 3, and 4 since the Ft. Wayne VA Medical Center and the Marion VA campus are outside my area. The veterans in the Lafayette area receive VA healthcare from both the Danville IL VAMC (which includes the West Lafayette Clinic) and the Roudebush VAMC in Indianapolis.

Congresswoman Carson I would like to applaud you and the other members of the Committee on Veterans' Affairs for the attention that you give our veterans. I have been sorely disappointed in the six years following my military retirement to have to look at DOD who I served for 22 years now as the adversary. I constantly read that when Congress looks at improving a veteran's benefit that the first people saying it can't be done is DOD. It's unfortunate that in serving our veterans that the funding seems to come from DOD's pocketbook. Would it be possible to incorporate a separate funding area for our veterans' needs?

Thank you for your time and GOD BLESS the UNITED STATES

Sincerely,

Randy Fairchild

STATE OF INDIANA

DEPARTMENT OF VETERANS' AFFAIRS
302 W. WASHINGTON ROOM E-120
INDIANAPOLIS, 46204-2738

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FRANK O'BANNON, GOVERNOR

WILLIAM D. "Bill" JACKSON, DIRECTOR

September 17, 2001

Democratic Staff Director
Subcommittee on Oversight and Investigations
333 Cannon House Office Building
Washington, DC 20515

Dear Mr. Durishin:

The following remarks are made at the request of Congresswoman Julia Carson as a follow-up to the field hearing held in Indianapolis on September 5th, 2001.

Question 1: Would you consider yourself, in your current, capacity as a stakeholder to any major change in Indiana impacting veterans' healthcare or benefits?

Answer: I am the Director of the Indiana Department of Veterans Affairs, and as such I represent the nearly 600,000 veterans within our State. I certainly do consider myself as a major stakeholder.

Question 2: What did you know, how and by whom were you informed, and when were you informed about proposed changes in the NIHCS to:

a. Consolidate the NIHCS long-term care to the Marion VA Campus;
b. Move sub-acute care to the Ft. Wayne Campus;
c. Eliminate all 16 medical beds at the Marion Campus; and,
d. Close 25 to 50 general psychiatry beds at the new General Psychiatry Hospital at the Marion Campus?

Answer:

a. I found out during the testimony given by Dr. Michael Murphy and questions asked of him after his testimony by the members of the Committee of the plan to consolidate the long-term care to the Marion VA Campus.
b. Dr. Murphy informed me the evening of September 4th at a reception in a private conversation about the movement of sub-acute care to the Ft. Wayne Campus.

c. Dr. Murphy informed me, in the same conversation listed in b, about the elimination of the beds.

d. I was informed during the testimony on September 5th about the closing of the 25-50 general psychiatry beds at the Marion Campus.

Question 3: Regarding Paragraph #2 above, were any other major stakeholders present when you were informed about those changes – who?

Answer: Many stakeholders were present in the room at the reception – The American Legion, VFW, DAV - but none to my knowledge were privy to the private conversation held by Dr. Murphy and myself. All were present at the field hearing, as well as additional staff of the U.S. Department of Veterans Affairs and the general public.

Question 4: Have you had any direct feedback from veterans regarding the changes proposed in Paragraph #2 above?

Answer: I have received several phone calls from veterans and Veterans' Service Officers regarding the changes. Most are not happy with the proposed changes.

Sincerely,

William D. Jackson
Director

WDJ:jh

Questions for Jay Kendall:

1. Would you consider yourself, in your current capacity, as a stakeholder to any major change in Indiana impacting veteran's healthcare or benefits?

2. What did you know, how and by whom were you informed, and when were you informed about proposed changes in the NIHCS to:

    a. Consolidate the NIHCS long term care to the Marion VA campus;
    b. Move sub-acute care to the Ft Wayne campus;
    c. Eliminate all 16 medical beds at the Marion Campus;and,
    d. Close 25 to 50 general psychiatry beds at the new General Psychiatry Hospital at the Marion Campus?

3. Regarding paragraph #2 above, were any other major stakeholders present when you were informed about those changes –who?

4. Have you had any direct feedback from veterans regarding the changes proposed in paragraph #2 above?

Questions/answers for Jay Kendall

#1. I am not a stakeholder. And I do not understand why you have to use the word stakeholder.

#2. I was informed by Director Murphy that the NIHCS long-term care and the sub-acute care were being consolidated at a VSO meeting on Jun 13, 2001.
I did not know of the option to eliminate all 16 beds or close 25 to 50 general psychiatry beds.

#3. No

#4. Yes, they were happy with long-term care at Ft Wayne, but really did not care where it was. Concerning the Acute care there were 4 or 5 vets that did not like the idea of it's closing. They did not want to be transported out of Marion to Ft Wayne unless it required specialized care. Nothing concerning the 25 to 50 beds.

The American Legion
Department of Indiana
777 N. Meridian Street • Indianapolis, Indiana 46204

September 20, 2001

Democratic Staff Director
Subcommittee on Oversight and Investigations
333 Cannon House Office Building
Washington, DC 20515

Dear Staff Director:

I appreciate the opportunity to answer The Honorable Julia Carson's letter of September 10, 2001.

My current position makes me very much a stakeholder to any major change in Indiana that impacts veterans' health care or benefits. Leadership responsibility for over 120,000 Legionnaires throughout the State of Indiana requires me to keep current with all veterans' issues, and forward the wishes of our membership to appropriate public officials whenever necessary.

VA informed us of some but not all plans involving consolidation of the Northern Indiana Healthcare System. Of course, we were aware of VA plans to consolidate administrative services of the Marion and Fort Wayne facilities several years ago. VA explained this to us well in advance. We understood VA would consolidate only administrative services and continue or improve existing medical care services at both facilities.

We learned though Legion site visits approximately two years ago that the Marion VAMC was reducing its sub-acute medical care and either transferring patients to the Fort Wayne VAMC or to the local public or private hospitals under VA contract. For example, veterans reporting to the Marion VAMC with symptoms suspect of a heart attack would be stabilized then transferred to one of the other medical facilities depending on the severity of the medical condition. VA had claimed it was force to reduce these types of services due to not having enough veteran patients to justify the need for full sub-acute medical care at the Marion VAMC. We suspect though that reduced services cause the drop in patient counts rather than veterans simply choosing to use private hospitals.

More recent NIHCS plans to reduce some medical beds and close other general psychiatry beds at the Marion VAMC have caught us by surprise. I cannot recall receiving official notification of these plans from the NIHCS, although NIHCS had provided information about advancements in medicine obviating the need for long-term hospitalization of psychiatric patients. I have inquired with my service department and several other stakeholders: i.e., the PVA National Service Office and County Service Officers in Huntington and Allen Counties, and they too cannot recall receiving official notice of plans to close patient beds at the Marion VAMC. Minutes of NIHCS Service Officers meetings also fail to show discussions of this issue until after the recent Congressional Subcommittee Hearing in Indianapolis.

If, though, as VA claims, recent medical advances now allow treatment of psychiatrically impaired patients without institutionalization, VA should not keep those patients hospitalized simply to fill beds. We have not received much, if any, direct negative feedback from veteran patients concerning this issue.

Thank you for sharing our concerns for maintaining an adequate veterans' healthcare delivery system.

Sincerely,

John J. Michalski, Commander
The American Legion Department of Indiana

Follow up Questions from
the Honorable Julia Carson, Ranking Democratic Member, HVAC
Subcommittee on Oversight and Investigations

September 5, 2001 Hearing Held in Indianapolis, IN

Questions for Linda Belton, Network Director, VISN 11

1. *Is there a strategic planning and performance document (circa 1995) regarding the goals and timeline for the integration of the Marion and Fort Wayne VA campuses into the Northern Indiana Health Care System? Please provide a copy of this document.*

RESPONSE: The only applicable file document located in the network office is a reorganization proposal from NIHCS, which was submitted to, and approved by, VHA's Executive Resource Board. The attached document details many of the goals and objectives of the reorganization and implementation actions. (Attachment A)

2. *Did NIHCS obtain approval from VISN 11 to:*
   Consolidate the NIHCS long-term care at the Marion VA campus;
   Move all sub-acute care to the Ft. Wayne campus;
   Eliminate all 16 medical beds at the Marion Campus; and,
   Close 25 to 50 general psychiatry beds at the new General Psychiatry Hospital at the Marion Campus?

RESPONSE: Approval for the consolidation of nursing home beds at the Marion campus and the closure of 16 medicine beds at the Marion campus was requested by NIHCS to the VISN on May 30, 2001, and requested by the VISN to VHA officials on June 8, 2001, with approval on July 16, 2001. There are no changes to the sub-acute rehabilitation unit at the Marion campus. Regarding psychiatry, current clinical efforts are focused on patient placement in the least restrictive, non-institutional setting. As this objective is met and sustained, it is likely there will be a diminished need for staffed and operating psychiatric beds. When this occurs, a request for bed closure will be forwarded per VHA policy and procedure. At this time it is estimated that 25 to 50 beds may no longer be needed for acute and long-term psychiatric care.

3. *Regarding the four proposed actions in paragraph #2 above, did VISN 11 review detailed cost/benefit analysis for each of the listed actions? Please provide copies of the full review including all cost/benefit analysis.*

RESPONSE: The nursing home care unit study and the sub-acute rehabilitation unit study are attached (Attachments B and C). The medicine bed closure at Marion has been discussed for a number of years, with documentation of plans

included in the FY99-00 Clinical Strategic Plan; *reference item 19 (below) of Director, NIHCS, response.* The efforts in psychiatry are based on contemporary clinical practice standards, e.g. medication, outpatient care, community placement, not on a particular study or review.

4. Regarding the four proposed actions in paragraph #2 above, did VISN 11 notify HQ VA or VHA regarding the proposed changes?

RESPONSE: See item 2 response above.

5. Regarding each action listed in paragraph #2 above, did VISN 11 assure all stakeholders in the region were consulted for each of the four changes? Include as a minimum, state veteran service representatives, veteran service organization representatives, media outlets, congressional offices, labor officials. Identify who, how and when these stakeholders were notified.

RESPONSE: VISN 11 officials have ongoing contact with NIHCS executives, managers and labor officials regarding program changes. These contacts include discussions of notification of key stakeholders. See item 5 (below) of NIHCS Director response for listing of many of the contacts made with stakeholders.

6. Is it more cost effective for the government and more convenient for the patient for the VA to treat a veteran at a VA medical center or to pay costs at a local non-VA hospital such as Marion General?

RESPONSE: Cost and convenience are largely dependent on the services available at a particular VA medical center, as well as the patient's condition and travel distance to the nearest appropriate care site. These factors are balanced in all cases, whether a veteran lives in a community with a VA medical center, e.g. Marion, Indiana, or in a community some distance from a VA medical center, e.g. South Bend, Indiana. The priority consideration is the veteran receiving the right care, in a timely manner, at the most appropriate care site.

7. What is the cost of a ground ambulance transfer of an acutely ill veteran from the Marion VA facility to the Ft. Wayne facility? What is the cost of a transfer from Ft. Wayne to the Roudebush Medical Center?

RESPONSE: Advanced Life Support (ALS) ambulance service with Paramedic is $275.00 per trip, plus $3.50 per mile one way. Basic Life Support (BLS) ambulance service with Emergency Medical Technician is $80.00 per trip, plus $3.50 per mile one-way.

Using these figures, the cost of transfer between Marion and Ft. Wayne is $495.50 with ALS and $300.50 with BLS. The cost between Ft. Wayne and the Roudebush VAMC is $722.50 with ALS and $527.50 with BLS.

8. What is the average response time (from initial call to arrival at Marion VA, ready to load) for an acute-care ambulance to arrive at the Marion campus from the Anderson, IN base of operations pursuant to a patient transfer to Ft. Wayne?

RESPONSE: Advanced Life Support (ALS) response time required by the contract is 1-1/2 hour(s). It further states that when NIHCS has a need for an "emergency run," i.e. a need to transport a patient within 30 minutes; or an "extreme emergency run," i.e. a need to transport within less than 30 minutes, the contractor will be informed of the "expedited" transport need. Non-emergent Basic Life Support (BLS) response time is four (4) hours.

9. Does the VISN Director encourage subordinate units to review State Nursing Home inspection reports prior to placing a veteran in a non-VA facility? What level of follow-up is encouraged for veterans placed in a non-VA home? If a nursing home scores very poorly on a state inspection, are actions taken to relocate the veteran to a safer facility–if so, provide appropriate data?

RESPONSE: Policy at every VISN 11 facility requires a satisfactory inspection of a private nursing home before the facility can enter into a contract with that facility. The inspection team consists of, at minimum, an RN, a social worker, and an environmental safety specialist. The team, in addition to physically inspecting the proposed site, reviews the latest State licensure inspection report and the latest HCFA (now CMS) certification–both of which are stringent and more detailed than required of VA inspections. Satisfactory documentation of remediation of all identified deficiencies must be furnished prior to finalization of contract arrangements. Once one (or more) veteran(s) is placed in a home that has met all applicable criteria, follow-up visits are conducted by a social worker at least monthly and by a registered nurse at least in alternate months. Visits involve a review and independent assessment of the veteran's status since the prior visit, the eliciting of veteran concerns, and addressing or beginning to address issues that arise.

On an annual basis the director of each VA's contract nursing home program examines the results of the State report and the CMS certification. Deficiencies will result in immediate cessation of placing veterans in that facility until the deficiency is addressed in a satisfactory manner and reviewed by those charged with oversight of the program. A deficiency of significant severity could, in theory, necessitate the immediate transfer of a veteran to another facility, but there has been no such occurrence in VISN 11 in memory.

10. Are there written discharge criteria or guidelines to reduce the patient population in the new inpatient psychiatric facility at Marion VA and if so, please provide a copy of the guidelines?

RESPONSE: There are no guidelines or criteria, per se, since our goal is clinically appropriate treatment for each patient, in the least restrictive possible environment.

NIHCS has implemented a psychosocial rehabilitation program which has the operating principles of helping patients be successful in the community, requiring patient's active participation in goal setting and discharge planning, and, focusing on motivational as well as functional rehabilitation. Hence, for each patient who is identified as being appropriate for community placement, an individualized treatment plan is developed, which includes assessment of readiness for discharge, availability of community placement resources and ongoing outpatient treatment and case management. As of August 2001, program outcomes include assessment of outpatient programs; approximately 100 staff have received education and training, with 18 staff trained as facilitators, and, 21 patient assessments completed.

11. As the Marion campus becomes the non-contract, long-term nursing home care unit for the NIHCS, should we expect the NHCU census to increase or decrease over the next ten years? How do we know this? Will there be an increased possibility for acute medical emergencies from the NHCU during that time frame?

RESPONSE: The table below reflects actual Average Daily Census figures for the NIHCS NHCU and the other options for VA-supported nursing home care for 1998-2000, and figures projected by the VA Long Term Care Planning Model for 2000, 2003, 2005, and 2010. Because the Model does not specify the actual mix among care sites (VA, contract home, State Home, etc.) that a VISN should achieve, only the total care census targets are provided, bottom right.

	Actual ADC			From Long Term Care Planning Model			
	1998	1999	2000	2000	2003	2005	2010
VA-NHCU	120	92	109				
Contract Nursing Home	45	37	13				
State Nursing Home	63	67	80				
State Domiciliary	8	4	7				
Total	236	200	189	153	185	195	210

These data show that NIHCS is in full compliance with Long Term Care Planning Model, specified by the VHA Planning Board, through 2003. In compliance with provisions of the Veterans Millennium Healthcare and Benefits Act, VISN 11 has submitted plans to the Assistant Deputy Under Secretary for Health (10N) demonstrating that NIHCS is targeting growth of its VA NHCU ADC to 125 by the beginning of 10/1/01; and to 140 by 4/1/02.

As VHA, VISN 11, and the NIHCS move increasingly toward utilizing less restrictive and more home- and community-based long term care options for the growing number of chronic care veterans, there is a concentration on admitting more

medically challenging patients in VA NHCUs. Staffing levels and competencies are, and will continue to be, established to meet care needs in the nursing home unit.

12. If the final 16 beds at the NIHCS south campus are closed and a long-term nursing care patient becomes acutely ill, requiring immediate stabilization, how will they receive care? What are the considerations once this patient becomes stable? Is a Marion NHCU to Marion General to Fort Wayne VA to Indianapolis VA MC possible?

RESPONSE: Enhanced staff competencies are being fostered at Marion to address the more compelling care needs of tomorrow's institutionalized elderly veterans. Such skill levels will minimize need for off-hours, unanticipated emergency care. Nevertheless, such care, when needed will be available through on-call staff or contracted off-hours medical coverage. As patients are stabilized, the appropriate transfer destination--Marion General, Fort Wayne, or Indianapolis VA--can be arranged and effected.

13. What was the cost of the 100-bed general psychiatry facility that was dedicated in early FY 2001?

RESPONSE: $17,873,145.

14. What needs or requirements studies were used to build the 100-bed general psychiatry facility that was dedicated in early FY 2001? When were they completed? Please forward a copy.

RESPONSE: The planning efforts for this project date back to the early 1990's and originally projected a new building of 154 beds to replace Buildings 1, 3, 4, 12 and 17. In approximately 1993, these plans were revised, reducing new building capacity from 154 to 100 beds because of the decreasing need for inpatient beds and shift to outpatient and community models of care. The most comprehensive documents on file in the network office are the Design Program, dated February 2, 1995, and the approved Memorandum of Agreement, dated May 1, 1995. Both of these documents are attached (Attachments D and E).

15. How does the aggregate score of VISN 11 currently rank among other VISNs with regard to psychiatric care, both inpatient and outpatient care?

RESPONSE: Mental Health programs in VHA are ranked on several domains; below are VISN 11 rankings for FY 2000 (lower ranking is better):

a. Outpatient follow-up after psychiatric hospitalization: 5th of 22
b. Screening for depression in primary care: 2nd of 22
c. Screening for abnormal movements for patients on neuroleptic drugs: 5th of 22
d. The network has a commitment to maintaining special emphasis programs while

implementing needed program changes, e.g. shift from inpatient to outpatient care. In the special emphasis programs of post-traumatic stress disorder (PTSD), Homeless, Substance Abuse and Seriously Mentally Ill, VISN 11 has achieved from 94% to 149% capacity in patients treated for the period FY96 to FY00 and has achieved from 72% to 176% capacity in dollars expended.

e. VA's Northeast Program Evaluation Center in New Haven, CT has published, since 1995, a yearly report entitled the National Mental Health Program Performance Monitoring System. This is a comprehensive analysis, utilizing VA corporate databases as well as U.S. Census data as sources, covering five major domains including: Access/Population Coverage (percent of veterans using mental health services); Inpatient Care (average length of stay, bed days of care before and after hospital discharge, readmission rates); Outpatient Care (access to and continuity of outpatient care after hospital discharge, continuity of care between mental health and medical-surgical care, continuity of care for dual-diagnosis patients); Economic Performance (equity of resource allocation for mental health vs. other health care, proportion of resources allocated for inpatient vs. outpatient care, per capita costs); and, Customer Satisfaction (general, mental health specific). Aggregate rankings for VISN 11 mental health programs for FY 2000 are as follows:

1. Access/Population Coverage: 22nd out of 22 (this is being addressed by deployment of mental health services in Community-Based Outpatient Clinics)
2. Inpatient Care: 17th of 22 (reflection of our continued reliance on long-term hospitalization for persistently ill patients; we are developing alternative treatment venues)
3. Outpatient Care: 18th of 22 (this will be addressed by redirecting resources from inpatient to outpatient venues of care)
4. Economic Performance: 21st of 22 (reflection of more expensive inpatient care and minimal shift, as compared to other networks, of care to outpatient services)
5. Customer Satisfaction: 7th of 22
6. Overall Rank: 20th of 22

Questions for Michael W. Murphy, Director, NIHCS

1. Is there a strategic planning and performance document (circa 1995) regarding the goals and timeline for the integration of the Marion and Fort Wayne VA campuses into the Northern Indiana Health Care System? Please provide a copy of this document.

RESPONSE: See Item 1 of Network Director's response.

2. Did NIHCS obtain approval from VISN 11 to:

a. *Consolidate the NIHCS long-term care at the Marion VA campus;*
b. *Move, all sub-acute care to the Ft. Wayne campus;*
c. *Eliminate all 16 medical beds at the Marion Campus; and,*
d. *Close 25 to 50 general psychiatry beds at the new General Psychiatry Hospital at the Marion Campus?*

RESPONSE: See Item 2 of Network Director's response.

3. Regarding the four proposed actions in paragraph #2 above, did NIHCS complete detailed cost/benefit analysis for each of the listed actions? Please provide copies of the full review including all cost/benefit analysis.

RESPONSE: See Item 3 of Network Director's response.

4. Regarding the four proposed actions in paragraph #2 above, provide documentation for the approval of each listed change.

RESPONSE: See Item 2 of Network Director's response.

5. Regarding each action listed in paragraph #2 above, were key stakeholders consulted for each of the four changes proposed in the NIHCS? Identify how, when, and to what degree stakeholders participated in the process or were notified? Include as a minimum the following stakeholder groups: state veteran service representatives, veteran service organization representatives, media outlets, congressional offices, and labor officials.

RESPONSE: Stakeholder notification and discussion is an important part of implementing change. These communications have been conducted with congressional offices, employees, labor officials and VSO's over the past several years, particularly over the past six months. It is virtually impossible to detail each and every contact and meeting, but examples include the following: June 1999 – presentation of clinical strategic plan to senior management, that plan having been developed by an interdisciplinary committee that included union representatives; June 2000 – copies of IG Combined Assessment Program (CAP) report provided to each Association of Federal Government Employees (AFGE) local president;

March 26, 2001 telephone briefing by Director to Congressman Buyer, with follow-up letter dated March 27, 2001; April 2001 – Health Services Research and Development Management Decision and Research Center (HSR&D MDRC) reviewers met with labor officials as part of their nursing home review; early June, 2001 – Chief, Patient Care Support Service departmental briefing to Ft Wayne nursing home unit staff, including AFGE local president; June 6, 2001 – briefing by Associate Director to Mr. Steve Howell of Congressman Souder's staff; June 7, 2001 the Chief, Patient Care Support Service briefed the Marion staff, including the AFGE Local 1020 Title 38 representative, concerning the changes to medicine; June 7, 2001 – briefing by Associate Director to Mr. Kurtis Moore of Congressman Buyer's staff; June 13-14, 2001 –county Veteran Service Officer meetings, providing notification and discussion of program changes; June 2001 – facility supervisory staff briefing on program changes; June 27, 2001 – briefing by Associate Director to Ms. Amy Whitehouse of Senator Bayh's staff; and August 8, 2001 – email message from Associate Director to both AFGE local presidents, with enclosure detailing proposed implementation plans of changes.

6. What is the cost of a ground ambulance transfer of an acutely ill veteran from the Marion VA facility to the Ft Wayne facility? What is the cost of a transfer from Ft Wayne to the Roudebush Medical Center?

RESPONSE: See Item 7 of Network Director's response.

7. What is the average response time [from initial call to ready to load the patient] for an acute-care ambulance to arrive at the Marion VA campus from its Anderson, IN base of operations pursuant to a patient transfer to Ft Wayne?

RESPONSE: See Item 8 of Network Director's response.

8. Does the NIHCS track Indiana State Nursing Home inspection reports prior to selecting a non-VA facility to provide nursing care for a patient? What level of follow-up is accomplished for veterans placed in a non-VA home? If a nursing home scores very poorly on a state inspection, are actions take to relocate the veteran to a safer facility - if so, provide appropriate data?

RESPONSE: See Item 9 of Network Director's response.

9. Are there written discharge criteria or guidelines to reduce the patient population in the new, 100-bed inpatient psychiatric facility at Marion and if so, please provide a copy of the guidelines?

RESPONSE: See Item 10 of Network Director's response.

10. How does NIHCS currently rank among other VA providers with respect to psychiatric care, both inpatient and outpatient?

RESPONSE: See Item 15 of Network Director's response.

11. As the Marion campus becomes the [non-contract] long-term nursing home care unit for the NIHCS, should we expect the NHCU census to increase or decrease over the next one to ten years? How do we know this? Will there be an increased possibility for acute medical emergencies from the patients in the NHCU during that time frame?

RESPONSE: See Item 11 of Network Director's response.

12. If the last 16 beds at the south NIHCS are closed and a long-term nursing care patient becomes acutely ill requiring immediate stabilization, how will they receive care? What are the considerations once this patient becomes stable? Is a Marion NHCU to Marion General to Ft Wayne VA to Indianapolis VA MC transfer possible?

RESPONSE: See Item 12 of Network Director's response.

13. What was the cost of the 100-bed general psychiatry facility that was dedicated in early FY-2001? When did construction on this facility begin in earnest as opposed to ceremonial groundbreaking?

RESPONSE: Cost - $17,873,145. Site clearing and demolition began 3/25/98.

14. What needs or requirements studies were used to plan the 100-bed, general psychiatry facility that was dedicated in early FY-2001? When were the plans completed? Please forward a copy.

RESPONSE: See Item 14 of Network Director's response.

15. For the period 1 January 2001 to 30 June 2001, how many patients presenting at the Marion campus with medical complaints were:

a. treated and released at Marion
b. admitted at Marion VA
c. transferred to Marion General
d. transferred to Ft. Wayne
e. transferred to Indianapolis
f. transferred to a facility not mentioned above

RESPONSE:

a. 182*
b. 201
c. 11*
d. not available (Interward transfer data is not maintained)
e. 18*
f. 1*

*Information systems do not track data in a manner consistent with the questions

asked. Numbers provided above are a best attempt to manually retrieve information from available paper records.

16. For the period 1 January 1999 to 30 June 1999, how many patients presenting at the Marion campus with medical complaints were:

a. treated and released at Marion
b. admitted at Marion VA
c. transferred to Marion General
d. transferred to Ft Wayne
e. transferred to Indianapolis
f. transferred to a facility not mentioned above

RESPONSE:
a. 198**
b. 226
c. 17**
d. not available (interward transfer data is not maintained)
e. 23**
f. 1**

**Information systems do not track data in a manner consistent with the questions asked. Numbers provided above are a best attempt to manually retrieve information from available paper records.

16. If a veteran presents at one facility within the NIHCS and is subsequently transferred elsewhere, what are the provisions for returning the veteran to Marion upon resolution of the medical problem?

RESPONSE: Patients are routinely transferred between units, depending on their care requirements. Transfers between Marion and Ft. Wayne are accomplished through physician-to-physician contact, with necessary coordination among nursing and social work services.

17. If a veteran presents at Ft Wayne VA in need of long-term nursing home care, according to current information, the veteran would be given the choice of transfer to Marion VA's NHCU or placement in a local nursing home facility. What percentage of long-term care patients volunteer for placement at the Marion NHCU? Are any veterans transferred to Marion NHCU against their wishes or in ignorance of their options?

RESPONSE: The transfer of nursing home beds from Ft. Wayne to Marion has been completed only in recent weeks and no data is available to respond specifically to the question. Nursing home discharge plans are carefully coordinated among clinical staff, patient and family to best meet care needs, as well as placement preferences, under current eligibility requirements.

18. What initiatives or services available in the NIHCS would warrant the title of a "Best Practice"?

RESPONSE: The emphasis at NIHCS continues to be on providing high quality health care services for all veterans in the appropriate clinical setting. We have expanded our efforts in serving homeless veterans by partnering with a provider in the Anderson area, through the Homeless Provider Grant and Per Diem Program. Additionally we work closely with the Homeless Task Force of Fort Wayne in supporting "stand downs" and other essential homeless services. Our Home Based Primary Care (HBPC) program provides in-home primary medical care services to approximately 100 homebound veterans with chronic diseases and terminal illnesses. Our Adult Day Health Care program provides psychosocial health care services and rehabilitation to veterans in an outpatient setting. Our Respite Care program provides care givers brief periods of needed relief from the responsibility of providing 24-hour care to their loved ones. We are working closely with the Indianapolis VAMC Psychosocial Residential Rehabilitation Treatment Program to identify and return long-term psychiatric inpatients to a community setting.

A Mental Health Intensive Case Management (MHICM) program was started in FY 1999 in an effort to return patients to and maintain them in a community setting. VISN 11 provided a grant in FY01 to implement a psychosocial rehabilitation model that will improve community rehabilitation efforts and train our providers in community placement programs. The driving force of this program is to improve the quality of life and the quality of care for those veterans whose psychiatric care does not require that they be treated in an institutional setting.

NIHCS received two each, two-year grants from VACO in FY01 to establish outpatient substance abuse and post-traumatic stress disorder treatment programs at the Fort Wayne campus to better serve the large veteran population of northeast Indiana, particularly those veterans residing in Fort Wayne and Allen County.

19. What are the cost savings and patient care advantages envisioned by closing the 16 medical beds at Marion prior to the upcoming CARES review?

RESPONSE: According to the facility's Clinical Strategic Plan FY99-2000, the potential for cost savings avoidance was $230,000 per year. The advantages were to avoid duplication of services, provide one level of care, and the availability of consultants and specialty services. The Plan cover page and applicable Strategic Action sheet are attached. (Attachment F)

20. On September 5, you testified that the need for nursing home bed space at Marion was to make up for the loss of nursing home bed space at Cold Springs Road and the consolidation of health care delivery at Roudebush. I understood that the Cold Springs Road 'nursing home beds' were for in patient rehabilitation only and that there were no long-term care beds in Indianapolis. If that were so, then nursing home beds at Marion could not have replaced Cold Springs Road long-term care beds. Is this so, to your knowledge? What other rationale was there for the Marion construction?

RESPONSE: At the hearing, program changes and construction were discussed for both nursing home and psychiatric services at NIHCS, generally, and the Marion campus, specifically. The nursing home planning and construction at the Marion campus of NIHCS were independent of Indianapolis' Cold Springs Road changes.

The need for (at the time), and the construction of, the new general psychiatry building at Marion were not justified by the Cold Springs Road changes of the Indianapolis VAMC. However, the reduced demand for hospital care for psychiatric patients has allowed NIHCS to be fully supportive of the care needs of veterans that would previously have been provided by Indianapolis.

The Facility Development Plan (FDP) for the Marion VA medical center, which is now a campus of the Northern Indiana Healthcare System, was completed in 1988. That plan identified the need for a 154-bed building to replace psychiatry patient care buildings, which at that time were 60 to 100 years old. Preliminary project design was done during fiscal years 1993 and 1994. When the project was submitted for funding in the President's FY 1997 budget it was reduced to 100 beds, as by that time changes in psychiatry care paradigms were already focusing on returning patients to the community and to the least restrictive environments, and the need for fewer beds at Marion was foreseen. The project was completed and the building opened for patient care in the fall of 2000. With the continuing emphasis on returning patients to the least restrictive living environment and the advancing development of psychotropic medications, alternatives to institutional care continue to reduce further the requirement for both acute and long term hospitalization of the chronically mentally ill.

Questions for Robert Sabin, Director, VAMC Indianapolis

1. There seems to be some concern about staffing shortfalls at Roudebush. Are there staffing shortfalls and what are you doing to correct the problem?

RESPONSE: Aided by our affiliation with Indiana University School of Medicine, the Indianapolis VAMC has been successful in recruiting and retaining a sufficient number of high quality physicians.

The Medical Center is exercising special effort to maintain a level of nurse staffing appropriate to the number and acuity of patients; there are typically fewer than ten vacancies in a staff of over 400 nursing personnel. Our nurse recruitment has been enabled by locality pay, which since January has allowed us to implement registered nurse salary increases of 6.25% to 7.0%. We are able to recruit the numbers required, but many new nurse employees are less experienced and require longer periods of orientation and precepting.

Recruiting and retaining radiology technologists and technicians have required the use of special salary rates and bonuses. The VAMC has used locum tenens or contract Nuclear Medicine Technologists and imaging technicians to fill gaps in staffing for a total of five man-months this year at the rate of about $13,000 per month.

2. Women veterans have different needs than do our male veterans - the Gulf War Era granted veteran status to large numbers of women, many of childbearing years. I am concerned by the absence of a woman's health clinic at Roudebush VAMC. What are you doing to meet the needs of our female veterans?

RESPONSE: The Medical Center has employed a full-time Women's Veteran Coordinator since 1994. Recently we have renovated space within Ambulatory Care, which is devoted solely to women's health needs. The gynecology clinic will relocate within the women's health program area October 1, 2001. We are in the process of hiring a Clinical Nurse Specialist as a Case Manager to assist in the continuity of care for our women veterans. Together, our multidisciplinary team, consisting of gynecologists, nurse practitioners, social workers, primary care physicians, psychiatrists, pharmacists and patient services assistants provides comprehensive care for women veterans. We are able to provide services to women of all ages including those of childbearing age. In our new Women's Health Program setting, the team will provide primary care, sexual trauma assessment and counseling, hormone replacement therapy, breast health, treatment for menopause and osteoporosis, assessment for obstetric care, and referral for infertility, obstetric care and gynecologic surgery.

3. Your statement addresses the total dollars collected by your medical cost recovery fund (MCCF). How does Roudebush rate in collections efficiency among other VA Medical Centers?

RESPONSE: Roudebush VA Medical Center collections from third parties for eleven months through August of this fiscal year totaled $10.6 million. This ranks Indianapolis as tenth among all VA Medical Centers in MCCR collections, and at 46 percent above the mean collections of comparable VAMC's. Further, in this same period Indianapolis VAMC collected an additional $1.2 million in revenue generated by services provided to TRICARE, Indiana University and other parties.

4. What is the average size of the PTSD seminar at Roudebush? Are you doing anything to reduce the ratio of patients to staff?

RESPONSE: The Psychiatry Ambulatory Care Clinic has approximately 150 patients enrolled in its PTSD program. There have been some staffing vacancies in the past year; however, those have all been filled, or are under recruitment. There are eight different therapy groups to which patients in the PTSD program may be assigned. The largest of these is the weekly "PTSD Support Group." The average number of patients who attend this group is 34. The clinical staff that run the group have frequently broached the need to divide the group into smaller ones; however they have been met with resistance from the veterans in the group who desire to maintain group relationships. Nonetheless, the plan is to divide this group into at least two smaller groups to enable each veteran to receive greater attention from the group therapists.

5. For maximum efficiency of operations between Roudebush and NIHCS, how would you reorganize the NIHCS? What studies or rationale do you base your opinion upon?

RESPONSE: Northern Indiana Health Care System (NIHCS) is realigning clinical services to deliver care consistent with contemporary standards and technology, and to assure a critical mass of patients essential to maintain staff competence. Indianapolis VAMC will depend on NIHCS for chronic psychiatric care of veterans for whom Psychiatric Residential Rehabilitation Treatment Program (PRRTP), Day Hospital and outpatient mental health care are insufficient. Further, other Indianapolis area veterans may be suitable for, and desire admission to long-term nursing care at NIHCS. Conversely Indianapolis VAMC has the critical mass of veteran patients to justify sophisticated medical and surgical evaluation, consultation and treatment and acute psychiatric assessment and treatment for appropriate NIHCS patients.

6. *What is the status of the proposed 94-bed nursing home on the Roudebush campus?*

RESPONSE: Beverly Enterprises plans to build and operate a nursing home on Indianapolis VA Medical Center property under an Enhanced-Use Lease agreement. Beverly had designed a 94-bed nursing home with the intention of providing care to veteran and non-veteran patients. A recent marked reduction in Indiana's Medicaid rates has discouraged Beverly from serving community patients. Accordingly, the firm is reassessing the size of the planned nursing home. A decision is expected by November 1 regarding the size and scope of the program.

1481 W. 10th Street
Room C5093
Indianapolis, IN
46202

September 20, 2001

Dear Ms. Julia Carson,

Ranking Democratic Member, Committee on Veterans' Affairs

I consider myself a stakeholder on any issue that impacts the Veteran's healthcare or benefits. Besides being an employee of the system, my personal life is also impacted. My father was stationed in Korea during the Korean War, and as such is entitled to use the veteran's benefits.

I am sure that you are aware of the shortage of Registered Nurses nationwide. Any R.N. working in the V.A. system does so, by choice. These RNs choose to and are dedicated to providing care to a group of Americans who donated part of their life to keep our Nation free. These are nurses continue to come to work during the money, supply and staff shortages. When you speak to these nurses, you get the strong understanding that it is an honor for them to care for veterans. Many of the R.N's that I work with have a military background.

I consider all taxpayers and veterans stakeholders in the veteran's healthcare system. As a R.N., I could find another job, without difficult, if any major changes made it so. However, it would not be V.A.nursing, which I enjoy. Other staff that provides care to the veterans may have more difficulty obtaining a job. The concern of all employees is how will major changes impact the veteran population. Our veteran population is elderly and most of them have low income. How will changes impact their ability to receive quality and well deserved care in a timely basis? Will they be able to travel a greater distance if needed? Caring for veterans is unique. When you give care for the general population, you may never see a patient again. When you care for a veteran, you see them again and again. You learn their medical history, their family, and their fears. They come to know the staff. They know that each time they have to come to the V.A. there is staff they know and who care about their needs. You share their happiness and sorrow. This is part of what makes the V.A. system one of the best and a reason why staff stay.

Staffing shortage impacts every service at the Medical Center. When one service is short of staff, all other services are affected. Someone must pick up the service not being performed or the veteran will not receive the care that is needed. When dietetics is short staffed, patients must wait on meals. When supply is short staffed, patient must wait on needed supply. When housekeeping is short staffed, the patient's areas are not cleaned. When pharmacy is short staffed, then patients do not receive medications on time. Each of these services provide indirect care to the veterans. However, they are vital services. Nursing shortages directly effects the veterans. Nursing is the one service that touches the veteran's 24 hours a day, 7 days a week. Nursing's primary objective is to provide quality care in a safe environment. A shortage in Nursing staff means the veteran will not receive some aspect of his care during the Nurses shift. This causes stress to both the patient and the nurse. The nurse must decide for each patient under his/her care, what is the least important piece of care that will not be given. A nurse knows that all aspects of care are important, but not all of the care will be given during a shortage. The veteran is the one who suffers. Some part of his care will not be

done. The veteran will wait longer for the nurse, medications, and physical assistance. This is what is happening at our medical center.

Sincerely,

Teri James
President AFGE Local 609

American Federation of Government Employees, AFL-CIO
Local #1020, 1700 East 38th St.
Marion, IN 46953

November 7, 2001

Democratic Staff Director
Subcommittee on Oversight and Investigations
333 Cannon House Office Building
Washington, DC 20515

Dear Mr. Len Sistek:

This letter is in response to the letter from the Honorable Julia Carson dated September 10, 2001.

Four questions were posed to me for a written response. The questions and answers are as follows:

1.) Would you consider yourself in your current capacity, as a stakeholder to any major change in Indiana impacting veteran's healthcare or benefits?

RESPONSE: Yes. I also represent all of the non-management (bargaining unit) employees at VA Northern Indiana Health Care System Marion Division. They are stakeholders from both the veteran and caregiver perspective because many employees of the VA are also recipients of VA services, including myself.

2.) What did you know, how and by whom were you informed, and when were you informed about proposed changes in the NIHCS to:

a. Consolidate the NIHCS long term care to the Marion VA campus;
b. Move sub-acute care to the Fort Wayne campus;
c. Eliminate all 16 medical beds at the Marion Campus, and,
d. Close 25 to 50 general psychiatry beds at the new General Psychiatry Hospital at the Marion Campus.

RESPONSE: Please refer to attached memorandum from the Associate Director of VA NIHCS dated July 6, 2001

2.) Regarding paragraph #2 above, were any other major stakeholders present when you were informed about those changes-who?
RESPONSE: No.

3.) What is the impact of staffing shortfalls on patient care at your facility?

RESPOSE:

Staffing shortages here have reached the point that overtime is required on all three shifts to meet minimal coverage of patient needs. Each patient care unit has a minimum staffing level. Even with overtime, the minimum staffing levels on all units are not consistently being met. This results in compromised patient care and increased injuries to patients and/or staff. Although overtime is being distributed on a voluntary basis, the continued long term dependence on overtime puts the patients at greater risk for errors in their care. Employees who continue to work overtime for long periods are tired, distracted, and prone to making errors while providing patient care. Employees are less likely to notice changes in behavior or signs and symptoms of a physical medical condition, which increases risk for

harm to both patients and staff. Here at Marion, a large percentage of our patients have some stage of psychological impairment. Patients with altered mental status sometimes require direct continued supervision from staff to prevent them from harming themselves or others. This is referred to as being placed on status. There are two levels of status: 1) One-to-one, meaning the patient is at the highest risk of harming himself or others (this level requires one staff member to remain with one patient at all times), and 2) Group status, meaning the patient is still at risk to self or others but risk has been lowered (requires one staff member to supervise up to three patients in the group). There have been several occasions that patients either have been put on a lower level of status or have been prematurely removed from status due to the lack of sufficient staff to cover all status patients. This has happened even though the patient's behavior warrants continuation of status. Under these conditions, some of the patients have then initiated or have provoked aggressive behavior, which has resulted in patient and or staff injuries.

We now have fewer recreational staff available, which has resulted in fewer recreational activities for the veterans. With fewer recreational staff available, recreation has attempted to reach more veterans by having more centralized group activities in the new recreation clinic. These centralized activities work out well for veterans that are not so mentally or physically challenged that they require a staff escort to attend these activities. With decreased nursing staff available, patients that need an escort to attend are not able to go. Some units do not have enough staff to enable them to release one nursing employee to take any of the patients on their unit.

Thank you for your time.

Sincerely,

William T. Overbey, President
AFGE, Local #1020