AUTHENTICATED
U.S. GOVERNMENT
INFORMATION
GPO

S. HRG. 108–679

TESTIMONY OF RONALD F. CONLEY, NATIONAL COMMANDER, THE AMERICAN LEGION

HEARING

BEFORE THE

COMMITTEE ON VETERANS' AFFAIRS UNITED STATES SENATE

ONE HUNDRED EIGHTH CONGRESS

FIRST SESSION

JULY 15, 2003

Printed for the use of the Committee on Veterans' Affairs

Available via the World Wide Web: http://www.access.gpo.gov/congress/senate

U.S. GOVERNMENT PRINTING OFFICE

95-698 PDF WASHINGTON : 2004

For sale by the Superintendent of Documents, U.S. Government Printing Office
Internet: bookstore.gpo.gov Phone: toll free (866) 512–1800; DC area (202) 512–1800
Fax: (202) 512–2250 Mail: Stop SSOP, Washington, DC 20402–0001

COMMITTEE ON VETERANS' AFFAIRS

ARLEN SPECTER, Pennsylvania, *Chairman*

BEN NIGHTHORSE CAMPBELL, Colorado
LARRY E. CRAIG, Idaho
KAY BAILEY HUTCHISON, Texas
JIM BUNNING, Kentucky
JOHN ENSIGN, Nevada
LINDSEY O. GRAHAM, South Carolina
LISA MURKOWSKI, Alaska

BOB GRAHAM, Florida
JOHN D. ROCKEFELLER IV, West Virginia
JAMES M. JEFFORDS, (I) Vermont
DANIEL K. AKAKA, Hawaii
PATTY MURRAY, Washington
ZELL MILLER, Georgia
E. BENJAMIN NELSON, Nebraska

WILLIAM F. TUERK, *Staff Director and Chief Counsel*
BRYANT HALL, *Minority Staff Director and Chief Counsel*

C O N T E N T S

JULY 15, 2003

SENATORS

	Page
Specter, Hon. Arlen, U.S. Senator from Pennsylvania	1
Prepared statement	2
Bunning, Hon. Jim, U.S. Senator from Kentucky	3

WITNESSES

Conley, Ronald F., National Commander, The American Legion; accompanied by Robert W. Spanogle, National Adjutant, The American Legion; Steve A. Robertson, Director, National Legislative Commission, The American Legion; and Peter S. Gaytan, Principal Deputy Director, Veterans Affairs, and Rehabilitation Commission, The American Legion	3
Prepared statement	9
Executive Report: A System Worth Saving	17
Articles by:	
Kelly, Jack, National Security Writer, Post-Gazette, July 15, 2003	64
Rosenblatt, Susannah, Times Staff Writer, LA Times, July 15, 2003	64

APPENDIX

Graham, Hon. Bob, U.S. Senator from Florida	71

TESTIMONY OF RONALD F. CONLEY, NATIONAL COMMANDER, THE AMERICAN LEGION

TUESDAY, JULY 15, 2003

U.S. SENATE,
COMMITTEE ON VETERANS' AFFAIRS,
Washington, DC.

The committee met, pursuant to notice, at 2:40 p.m., in room SR–418, Russell Senate Office Building, Hon. Arlen Specter (chairman of the committee) presiding.

Present: Senators Specter and Bunning.

OPENING STATEMENT OF HON. ARLEN SPECTER, U.S. SENATOR FROM THE STATE OF PENNSYLVANIA

Chairman SPECTER. Good afternoon, ladies and gentlemen. We will convene the hearing of the Veterans' Affairs Committee of the United States Senate.

As this hearing assembles we are honored with the presence of Mr. Ronald F. Conley, National Commander of the American Legion. The American Legion is the foremost organization of veterans. The first veteran I knew, my father Harry Specter, was a member of the American Legion. I am not 100 percent sure that he paid his dues. He was a member of the American Legion during the Depression, and I think he planned to pay his dues with the $500 bonus which the Federal Government promised World War I veterans. When they reneged on the promise, I don't know that he had the money to pay the dues to the American Legion.

But one of my earliest recollections—and I am not 100 percent sure that I recall the event or whether I recall it having been told to me—was a veterans' march on Washington to get that bonus. Today, when there is a demonstration in Washington, they roll out the red carpet. For the veterans who came that day, they rolled out the cavalry with drawn sabers. The major in charge of the cavalry was George C. Patton, and in command was the chief of staff, Douglas MacArthur. There is a famous picture taken on The Mall of MacArthur standing next to his aide-de-camp, Dwight Eisenhower. Veterans were killed on that day, one of the blackest days in American history.

But I remember as a youngster growing up in Wichita, Kansas, my father's best friend, Max Greenberg, was in the cavalry and lost his hearing. He would come over for breakfast every Sunday morning. My brother's name was Morton. Max would always say, in Yiddish, "Was macht du, Martin?" He knew him for 20 years, but he

didn't know his name was Morton instead of Martin. But he was a proud American Legionnaire, and it is a great, great organization.

Ron Conley is now closing his term as the American Legion's National Commander, and he is going to report on his very active travel through the United States. It is very impressive that Mr. Conley has visited 60 of the VA's 171 medical centers since he was elected National Commander, and he has some interesting and important observations and recommendations to offer to the committee.

I want to thank you very much, Ron, for your fact-finding work. My full statement will be made a part of the record, and I am going to be relatively brief. It is too late now to be brief, but I am going to be relatively brief.

[The prepared statement of Chairman Specter follows:]

PREPARED STATEMENT OF HON. ARLEN SPECTER, U.S. SENATOR FROM PENNSYLVANIA

Good afternoon, ladies and gentlemen.

The purpose of the Committee's hearing this afternoon is to receive the testimony of Mr. Ronald F. Conley, the National Commander of The American Legion. I am proud to be able to say that Mr. Conley is a constituent; Ron hails from the Pittsburgh area where he is also a member of Steamfitters Local 449, where he has served on the examining board, on the finance and election committees, and as a union steward.

Mr. Conley joins us today, as he closes his 1-year term as The American Legion's National Commander, to report on a year of very active travel throughout the United States. Mr. Conley has personally visited 60 of VA's 171 medical centers since he was elected National Commander in August 2002—and he has some interesting and important observations and recommendations to offer to the Committee. We will be very attentive to those observations and recommendations for we know they come from Mr. Conley's conversations with veterans throughout the Nation.

Ron, I want to thank you for your fact-finding work—and I want to thank you also for initiating the Legion's "I Am Not a Number" campaign. The Legion is oh-so correct: veterans are real men and women—men and women who answered the call to service. They are not numbers or "cases" or "claim folders." VA—and the Congress—needs to be reminded of this from time-to-time.

Before I turn the Floor over to Mr. Conley, let me share with all who are assembled today just a quick rundown of Ron Conley's life of service. As I have previously stated, Ron Conley is currently the National Commander of The American Legion. Prior to assuming that very high position, Ron served in numerous other American Legion posts including:

I. Alternate National Executive Committeeman (1988–1992);
II. National Executive Committeeman (1992–present);
III. Department of Pennsylvania Vice Commander (1983–1984); and
IV. Department of Pennsylvania Commander (1987–1988).

Ron also served as President of the Pennsylvania American Legion Convention Corporation, which hosted the 1993 National Convention in Pittsburgh. Perhaps most importantly, Ron is the Founder and President of the American Legion for Homeless Veterans Corporation, an entity which operates eight residential and treatment facilities for homeless veterans in the Commonwealth of Pennsylvania.

Ron served as an air policeman in the United States Air Force from 1963 to 1966. He is an active leader of his union—Steamfitters Local 449 in Pittsburgh, PA—and has been married for 39 years to the former Barbara Lou Dilgen. Mr. and Mrs. Conley have been blessed with five children and nine grandchildren.

Ron, the floor is yours.

Chairman SPECTER. We customarily have a time clock, but we are not going to put it on for you, Commander Conley. We are going to let you speak at will, as the expression goes, but not until we have heard from my distinguished colleague, Senator Bunning of Kentucky.

Senator Bunning.

OPENING STATEMENT OF HON. JIM BUNNING, U.S. SENATOR FROM THE STATE OF KENTUCKY

Senator BUNNING. Thank you, Mr. Chairman.

Mr. Conley, I am glad you are here today to give us a report on your work and findings as National Commander of the American Legion. You have put in much hard work over the last year, and I applaud your service to our veterans and their families.

I am very impressed with your efforts to visit as many of the VA medical centers across this country. You have visited all three in Kentucky and made very candid assessments of each, and I appreciate that very much.

The VA medical centers in Kentucky face problems similar to others across the Nation. Demand for VA health care is higher than the Department's ability to provide that care. Long waits to see a doctor are unacceptable but very common. I think we have seen some progress in recent months, but the Department still has a long way to go.

One of the most prevalent issues and problems that you have found were staffing issues. Some facilities do not have enough personnel, and we need to be sure we are hiring the best people for the job. I think everyone on this committee is dedicated to ensuring our veterans receive the best care possible in a timely manner. I know I am. Your report and recommendations will help us to do just that, and I thank you for being here.

Thank you, Mr. Chairman.

CHAIRMAN SPECTER. Thank you very much, Senator Bunning. Commander Ronald F. Conley, we await your discourse. The floor is yours.

STATEMENT OF RONALD F. CONLEY, NATIONAL COMMANDER, THE AMERICAN LEGION; ACCOMPANIED BY ROBERT W. SPANOGLE, NATIONAL ADJUTANT, THE AMERICAN LEGION; STEVE A. ROBERTSON, DIRECTOR, NATIONAL LEGISLATIVE COMMISSION, THE AMERICAN LEGION; AND PETER S. GAYTAN, PRINCIPAL DEPUTY DIRECTOR, VETERANS AFFAIRS AND REHABILITATION COMMISSION, THE AMERICAN LEGION

Mr. CONLEY. Senator Specter, Senator Bunning, we want to thank you for the opportunity to appear here this afternoon to give you our assessment, but before I get into my oral statement, I would like to introduce publicly to you the National President of the American Legion Auxiliary, Elsie Bailey, from New Jersey.

[Applause.]

Mr. CONLEY. We also have with us Past National Commander from the State of Maryland, Clarence Bacon.

[Applause.]

Mr. CONLEY. We have John Brieden and Tom Cadmus that are candidates for National Commander of the American Legion, and we have Paul Moran, Ed Dentz, and Terry Lewis that are chairmen of VA in our Legislative Council. We also have Mr. Johnson, our National Vice Commander, here and, of course, Senator——

[Applause.]

Mr. CONLEY [continuing]. You know Dr. Sebastianelli from Pennsylvania, who is a Past National Vice Commander.

Again, I want to thank you for the opportunity to be here and give you our assessment of the VA hospitals, a system worth saving. As National Commander of the Nation's largest veterans' service organization, I pledged to visit at least one VA health care facility in each State. With the information I gathered through face-to-face meetings with faculty staff, firsthand reports from the very veterans who comprise the 200,000-plus backlog of patients waiting for appointments at VA, and surveys submitted by the facility directors, the American Legion has developed a comprehensive report dealing with the obstacles faced by the VA to ensuring the timely delivery of quality health care to America's veterans.

This report was guided by both duty and privilege. It has been my honor to meet firsthand so many talented people who fulfill our Government's health care obligations to veterans. I investigated more than 60 VA facilities throughout America, the Philippines, and Puerto Rico in the past 10 months, and the information I gathered along the way reinforces the American Legion's belief that the VA is indeed a system worth saving. In touring these facilities, I made a conscientious effort to break from the beaten path. I compared comments from administrators and public affairs staff with the more experienced opinions of hard-working doctors, nurses, and technicians on the front lines. I also spoke with thousands of veterans and their families who entrust their lives to this system.

Among VA employees, I witnessed strong dedication, professionalism, safety awareness, and resourcefulness. Among veteran patients, I heard profound gratitude voiced for the quality of care they had received. But from nearly everyone, I also found frustration over the lack of timely access to VA health care, under use of some facilities, overcrowding in others, and an inconsistent budget and budget expectations.

America's excellent VA health care system is being consumed by physical neglect. It is my duty as the leader of the veterans to share my findings with those who have the power to change it and to inform the public of the conditions that exist and the reasons we believe they exist. It has been an eye-opening journey.

My first stop was Dallas, Texas, last September 20th. There I found the first in a long line of facilities where capital improvements have been shelved for the sake of hitting the bottom line. The Alzheimer's unit there is in an I-shaped building and operates in the 1940s. In order to monitor the Alzheimer's patients, they put an LPN nurse in a school chair at the end of the hall, and that is the care and treatment they get in that facility. It has been on the books to try to build a new facility. The first cost was $19 million. It has now been readjusted to $33 million, but it has been placed on hold because of the CARES process.

In Bay Pines, Florida, I encountered a VA medical center where the list of veterans' waiting time is 6 months or longer for primary care appointments. But it has been reduced to 14,000 waiting.

In Prescott, Arizona, no one knew how many registered nurses worked in the hospital or how many new veterans were enrolling each year. I later learned that that particular facility, where patient numbers have been more than doubled since 1997, is on the chopping block because of CARES.

In Salisbury, North Carolina, the director said that 75 new doctors and $17 million are coming soon to solve that medical center's problems, a five-figure backlog. Why an increase at this particular facility and where was the money coming from? The director said he did not know, but he was sure it was coming.

In Cheyenne, Wyoming, a hospital doctor explained that his patient load had risen from 6,000 to 13,000 in the same period that his staff numbers had been cut from 385 to 340.

A director in Louisville, Kentucky, said the VA hospital under his supervision simply needs to be torn down and rebuilt. One emergency room doctor there can expect to treat 50 or more veterans a day.

A director in Manchester, New Hampshire, simply told me that veterans would be better served in a non-VA facility.

Throughout America, it is obvious VA health care operations are being forced to do more with less. Demand has soared and the funding has failed to keep pace. Staff shortages are everywhere.

In Cheyenne, the hospital director, a doctor himself, treats patients alongside the physicians under his supervision. That facility, where demand was more than double while staffing has decreased by over 10 percent, must routinely shuffle patients from floor to floor to put veterans near caregivers. There, they are forced to perform the kind of triage one might expect on a battlefield but not in a VA hospital.

At Edward Hines, Jr., VA Hospital in Illinois, there are seven vacancies for spinal cord specialists. Despite finder's fees and signing bonuses, they still experience hiring difficulties.

In many locations, VA facilities are forced by urgent demand to fill in with agency-contracted nurses, part-time doctors, and short-term foreign physicians under J–1 visas. Doctors hired under J–1 visas are required to practice for a minimum of 3 years at a VA facility. Once that obligation is met, many physicians leave the VA health care system and begin practicing in the private sector, which does not solve VA's long-term staffing shortages. What is worse is these same doctors could possibly be contracted by the VA to provide care at a much higher cost. We think this entire program needs revision.

Staffing shortages result in closed beds, wards, emergency rooms, nursing homes, and intensive care units. The shortages force patients for whom the facilities were built to be turned away. Shortages force the VA Secretary to reverse the clear intent of the Veterans Health Care Eligibility Reform Act of 1996 by once again restricting enrollment only to the poorest and the sickest among those who served.

To its credit, America's budget-strapped veterans' health care system does not ration quality. Unfortunately, because the funding pie cannot be cut into enough pieces for all, VA must ration access. This is why tens of thousands of veterans are waiting in line to see doctors. What good is high-quality care if you cannot get an appointment to receive it?

As outlined in the President's budget, Priority 7 and 8 veterans will pay a $200 annual enrollment fee. This proposal is meant to drive out 1.2 million veterans from the VA health care system. That is unacceptable.

Capital improvement measures to cope with recent demand growth remains stalled under the CARES recommendations. Suspending all capital improvements until the completion of CARES is proving detrimental in many locations. In Indianapolis, the director reported his facilities must expand immediately to handle the current patient load and to accommodate all the projected growth. Meanwhile, VA facility directors in other parts of the country are using up their capital improvement reserves to handle day-to-day operations. The final CARES recommendations must enhance services for CARES and not simply realigning capital assets to downsize the system.

Another area of concern is the VA requirement that each hospital hire a minimum of two full-time armed police officers per shift, as well as installing new electronic surveillance equipment. This mandate was not funded, however. Hospital directors have been forced to borrow from their medical budget to meet the new security requirements. Funneling funds from the medical budget means fewer doctors, nurses, technicians, and pharmacists.

Since its creation, the VA health care system has worked side by side with the Nation's medical schools. The value of VA's affiliations with medical colleges and nursing schools is beyond dispute. Ninety percent of the doctors at the VA Connecticut Health Care System in West Haven, Connecticut, are affiliated with Yale University. The University of Pennsylvania Medical School runs the Philadelphia VAMC Emergency Room every night.

The University of South Carolina School of Medicine, a national leader in colorectal cancer research, shares the same campus at the VA Medical Center in Columbia, South Carolina. On any given day, 50 or more university physicians and interns work in that VA facility.

One VA medical center reported having affiliations with 68 different institutions of health care education. But when VA facilities are downsized out of the proximity to their medical school partners, their relationships are gone forever.

This is happening right now in Chicago, where Lakeside VA Medical Center is merging with a sister facility on the other side of town, effectively dissolving VA's long and successful relationship with Northwestern University Medical School. Neither the veteran stakeholders nor the university administration had a voice in that decision.

When I visited Lakeside Division of the VA Chicago Health Care System on May 17th, I was told their patient population is mostly poor, indigent, and unemployed veterans. The hospital property has been valued as high as $100 million by the VA. In an effort to keep a VA hospital in the downtown Chicago region, Northwestern University developed an alternative plan that would allow VA to assume ownership of Prentiss Women's Hospital located across the street from the current Lakeside Hospital. VA rejected that proposal and seems determined to sell the property.

Eliminating VA health care services from Chicago will prove detrimental to the local veteran population who will not be able to travel across the city to the Hines facility. Currently, Northwestern provides more than 300 doctors at no cost each year to Lakeside VA Medical Center. Once Lakeside is closed, the value of affiliation

with Northwestern in terms of expenses saved and veterans treated will be difficult to recover.

Nearly all the strategies suggested to resolve VA's access crisis have focused on reducing access, outsourcing services, or finding ways around paying the actual costs of providing care. Downsizing is not the answer.

Last January, the decision to cutoff new enrollment of Priority 8 veterans was made in the interest of stemming demand the VA health care system could not handle with existing appropriations. However, by cutting off that particular group, the system lost the population of patients most likely to have health insurance policies and the ability to share in the cost of their care. I found this decision especially ironic after having heard frustration from every corner of the country about VA's expectation for third-party reimbursements. Last year, in Puerto Rico, third-party reimbursements target was $8 million. The facility beat it by $200,000. This year, the target was doubled to $16 million, a figure their director says is at least $5 million too high.

I was also told a collection agency receives 25 percent of third-party reimbursements collected in Puerto Rico. In Minneapolis, the third-party reimbursement jumped from $15.5 million to $23 million. In Ann Arbor, Michigan, the target was $7.5 million for third-party reimbursements. They did not make it. They only collected $6.5 million. But their new target this year is $11 million. That to me means a cut of services for the veterans in that area.

Many directors I spoke with agreed that it is doubtful major increases in third-party reimbursements targets can be reached this year because the population of veterans driving that revenue stream has been removed from the equation.

Scarcity of budget dollars creates competition among VA facilities and inconsistent veteran care as a result. How else can you explain shortage-based backlogs of 10,000 or more, such as in Bay Pines, Florida, when only 750 miles away from that facility in Jackson, Mississippi, they have next-day care?

A mandatory appropriations model for VA health care would help ensure VA is funded at a level needed to reach the demand for care. Funds must be allocated on a cost-per-veteran basis, indexed annually for inflation. In addition to mandatory funding for VA health care, the American Legion supports allowing all veterans with the ability to use their insurance, including Medicare and HMOs, to choose VA facilities for their health care regardless of economic status or level of service-connected disability. They would be required to reveal any insurance coverage they have and make reasonable co-payments for treatment of conditions unrelated to their military service. For those veterans who don't have health insurance, VA can offer a premium-based health care benefit package.

Mr. Chairman, my entire year as Commander has been spent collecting examples of many ways in which the discretionary appropriations model fails to fulfill the care giving purposes of the VA. Mandatory funding models supported by the American Legion, coupled with revenue-generating programs such as Medicare reimbursement and premium-based health care plans, will help to boost VA funding to a level that will allow VA to meet the increased de-

mand for care. History has proven that 30-percent increases in demand cannot be served by 7-percent increases of funds.

The Department of Veterans Affairs is America's biggest managed care system. It is a national treasure, a good reason for any young man or woman to serve in the United States Armed Forces. This health care system was created to treat the unique health care needs of America's veterans.

Call it a debt. Call it an obligation. Call it a promise. The VA health care system serves tens of thousands of men and women who were willing to give their lives for the freedom of all others who make America their home.

Mr. Chairman, I did not come here today to simply point out the deficiencies in the VA health care. I have come prepared to offer recommendations.

The American Legion recommends an open exchange of information leading to the final recommendations of the CARES process. Any CARES recommendations should be considered in the context of a fully utilized VA health care system that takes into consideration the tenets of the GI Bill of Health, VA/DoD sharing, the Veterans Millennium Health Care and Benefits Act, and the mission of the Department of Homeland Security. VA must also provide a list of capital assets to the Department of Homeland Security for consideration and strategic planning at the local, State, and national levels.

The American Legion supports the mutually beneficial affiliations between VA and the medical schools of this Nation. The American Legion also recommends appropriate representation of VA medical school affiliates as stakeholders on any national task force, commission, or committee established to deliberate on veterans' health care.

The American Legion recommends Medicare reimbursement for the VA on a fee-for-service basis for the treatment of nonservice-connected medical conditions of enrolled.

The American Legion recommends that Congress designate VA health care as mandatory funding and provide discretionary funding required to fully operate other programs within the Veterans Administration. Additionally, Congress should provide supplemental appropriations for budgetary shortfalls in the VHA's mandatory and discretionary appropriations.

The American Legion recommends the expansion of VA's third-party reimbursement to include Medicare reimbursement as well as optional premium-based health care plans for those veterans choosing to seek treatment for nonservice-connected.

Mr. Chairman, from the founding of this great country to the present, America has recognized its obligation to the men and women of the Armed Forces—past, present, and future. As a grateful Nation providing timely access to quality health care, transitional assistance from military service to civilian life, timely adjudication of disability claims, and a final resting place continue to be a moral, ethical, and legal obligation.

Recently, new terms like "core veterans" and "traditional users" have been used to serve as justification for America's failure to meet the health care needs of its veterans. Yet neither term ap-

pears in Title 38 United States Code. Such terms appear only in the minds of bureaucrats.

Mandatory funding for VA health care will provide a more accurate mechanism for funding VA medical care at a level that will ensure VA has the ability to serve all eligible veterans and to meet its self-imposed access standards: 30 days for primary care appointment, 30 days for specialty care appointment, and an average waiting time of 20 minutes.

Rationing health care by denying access to Priority 8 veterans is not the answer. Charging an annual enrollment fee for certain priority groups is not the answer. Raising co-payments for outpatient services is not the answer. Raising co-payments for prescriptions is not the answer. The answer is designating VA medical care as mandatory funding within the Federal budget.

Mr. Chairman, veterans have served, are serving, and will continue to serve this Nation in an uncharacteristic manner—putting duty, honor, and country before self.

If America can find the money to bail out failed savings and loans institutions, commit troops to peacekeeping missions, rebuild foreign governments, provide health care for Third World countries, provide health care to those incarcerated in our prisons, and forgive loans to foreign countries, then surely America can find money to provide the needed care for America's veterans. This is what veterans want, and I believe it is what America believes is right.

Mr. Chairman and Members of the Committee, that concludes my testimony, and I ask that a full copy of the final report be included in the record. Please excuse me for my voice, but I have not gotten adjusted from coming back from Europe and then going to Texas and Oklahoma and then here. I have developed a nice cold. So please excuse my raspy voice.

[The prepared statement of Mr. Conley follows:]

PREPARED STATEMENT OF RONALD F. CONLEY, NATIONAL COMMANDER, THE AMERICAN LEGION

Chairman Specter and Members of the Committee, thank you for allowing me to testify today. Last September during a hearing before a joint session of the Committees on Veterans' Affairs, I made a promise to report back to you and your colleagues the results of my extensive visits to VA medical facilities across the United States. This final report spotlights my personal observations during visits to 60 VA medical facilities.

These visits were thorough, in depth, and probing. I preceded these visits by providing a list of specific questions to each facility to answer and return to The American Legion. Initially, I asked each VA medical facility director a few questions while meeting with them. However, over the course of my visits, the number of questions I asked increased as I became aware of the areas that needed extra attention.

ENROLLMENT

In 1996, Congress enacted legislation authorizing all eligible veterans to enroll in the VA health care system, within existing appropriations. This legislation changed years of complicated rules and regulations governing eligibility to health care. The complexity of this paradigm created confusion among providers, as well as patients. Frequently, rules were bent, stretched, or ignored to meet the health care needs of patients. There were no defined health benefits packages, no reliable data projecting future patient population, and no major effort to capture third-party reimbursements or co-payments for the treatment of nonservice-connected medical conditions. Access to the system was severely limited to only three groups of veterans: service-connected disabled veterans, other disabled veterans, and economically indigent veterans. VA's patient population in 1996 was about 10 percent of the total veterans'

population. Once VA opened enrollment, it attracted new patients for several reasons:

- Quality of health care provided,
- Patient safety record,
- Accessibility,
- Pharmaceutical program,
- Specialized Services, especially long-term Care,
- Affordability, and
- VA's affiliation with medical schools.

Following the eligibility reform of 1996, many Medicare-eligible veterans enrolled in the VA health care system, not only for access to quality medical care, but also to benefit from VA's low co-payment prescription program. Initially, VA's co-payment for nonservice-connected medications was $2 per 30-day supply. Even when Congress allowed VA to increase this co-payment from $2 to $7, veterans continued to enroll. Now VA has an enrolled patient population of nearly 7 million veterans, over half of them are also Centers of Medicare and Medicaid Services (CMS) beneficiaries as well.

In January 2003, the VA Secretary suspended enrollment of Priority Group 8 veterans—regardless of their service-connected disabilities, their third-party insurance coverage, or their ability to pay for care. Those with service-connected disabilities are authorized to seek treatment of their service-connected medical condition, but are not authorized to enroll for treatment of their nonservice-connected medical conditions.

From the very beginning of my term as National Commander, I was aware of lengthy waiting lists for primary care; however, I did not grasp the magnitude of the problem until I began to visit VA medical centers. Initially, I thought these waiting lists were just regional problems, but soon realized it was system wide. I discovered the deplorable conditions resulting from VA's inability to meet its own established acceptable access standards. VA's access standard for a primary care appointment is 30 days—extremely modest compared to nearly every other health care delivery system, public or private. Personally, I would find that standard unacceptable for my private health care system. In actuality, some veterans have waited longer than the standards—even as long as 2 years or more. Clearly, a patient could die while waiting for care—and, sadly, some have. Unfortunately, only a few isolated exceptions are meeting VA's own acceptable access standards for primary care.

As staggering statistics of thousands of veterans waiting 6 months or longer for their initial VA appointments became public knowledge, I was reminded of a statement made by former National Commander F.W. Galbraith during an American Legion meeting in 1920:

> "The trouble is that the men in these hospitals are 'cases.' They are represented by so many pieces of paper in some bureau in Washington. We want to humanize the whole thing, and say, 'Here is Jim Smith's case, my friend. What do you propose to do about him?' That is the thing that we want to do, and we can do it. It is our primary motive for living."

To evaluate the severity of this situation, The American Legion developed a program to put a "human face" on the growing problem—thus the "I Am Not a Number" campaign began. Veterans across America were asked to share their personal experiences in the VA health care system. These are my comrades, not just statistics. Thousands of veterans responded to The American Legion's survey between November 2002 and February 2003. Stories of frustration stretch from coast-to-coast.

The survey form was established and distributed to help develop a global picture through self-reporting. The survey sought veterans' self-assessment of their health care delivery system. Some reports were favorable, while others were extremely critical. On the whole, those veterans actually receiving care were pleased with the quality of that care and the professionalism of their VA health care providers. Predictably, those waiting 6 to 18 months were far more critical of the lengthy delays and perceived indifference toward their situation. Complaints of multiple rescheduled appointments were common. The results of this survey reveal problems throughout the VA health care system. The bottom line: too many veterans are being denied timely access to quality health care. The "waiting game" is being played at nearly every VA medical facility across the country. And America's veterans are suffering.

The American Legion prepared a short video, which I have provided to your staff, in which veterans tell their own personal stories. I hope you and your colleagues will review this video. It highlights the obstacles encountered by the men and women—veterans of the Armed Forces—attempting to access the VA health care

system. These individuals aren't the only ones with stories to tell. There are tens of thousands of veterans just like them, nationwide.

Mr. Chairman and Members of the Committee, if you or a member of your family were ill and in need of health care, would you find it acceptable to wait 6 months to a year for a primary care appointment? How would you feel if you were eligible to enroll as a result of your honorable military service, but were prohibited from enrolling because you earned more than $29,000 a year or lived in the wrong geographic area?

DEMAND VS. FUNDING

Recently the President's Task Force to Improve Health Care Delivery to Our Nation's Veterans (PTF) issued its final report. Among the many areas discussed in that report, one issue stands out—the current mismatch between demand for timely access to care and Federal funding throughout the VA health care system. Not only does this crisis prohibit meaningful collaboration between VA and the Department of Defense (DoD), but it also causes uncertainty about VA's ability to fulfill its four primary missions.

The PTF recommended full funding of VA to care for all enrolled Priority Group 1–7 veterans. However, the best recommendation the PTF could reach to address Priority Group 8 veterans was for the President and Congress to study and resolve the mismatch problem. This was the only recommendation on which the PTF Commissioners failed to reach consensus. This is truly unfortunate since Priority Group 8 comprises the majority of veterans; therefore, future access to VA health care remains uncertain for them—at least for now.

Three PTF Commissioners offered a dissenting opinion regarding the funding of Priority Group 8 veterans, which is supported by The American Legion. The recommendations outlined in this dissenting opinion place a financial obligation on each enrolled Priority Group 8 veteran. Mr. Chairman, I would encourage you and your colleagues to consider these recommendations.

MEDICAL CARE COLLECTION FUND (MCCF)

Although adamantly opposed by The American Legion, all third-party reimbursements and co-payments collected by VA's MCCF are scored as an offset against VA's annual discretionary appropriations. Since this money is for the treatment of non-service-connected medical conditions, The American Legion continues to advocate scoring MCCF as a supplement to VA's annual medical care appropriations.

During my visits, I discovered that MCCF is handled differently from medical facility to medical facility. Some MCCF activities are contracted to private collection firms, while others are done internally. This year, VA's MCCF collections were the highest ever, yet its actual collection rate is extremely low compared to the industry standard. Since VA is prohibited from collecting from CMS for the treatment of non-service-connected medical conditions of CMS beneficiaries, VA bills CMS in order to collect from private medical supplemental policies.

With a patient population comprised of more than 3.5 million CMS beneficiaries, VA medical facilities cannot realize their full potential in MCCF collections. Nearly every VA medical facility I have visited is expected to increase MCCF collections in fiscal year 2003. Yet, the President's budget request for fiscal year 2004 seeks to drive away as many as 1.2 million Priority Group 7 and 8 veterans by authorizing increased co-payments and an annual enrollment fee.

Both Indian Health Services (IHS) and DoD's TRICARE effectively used third-party reimbursements, co-payments, and premiums to supplement their discretionary appropriations and resolve the demand versus funding crisis. IHS turned to third-party reimbursements from CMS and the private sector to help improve quality of care and timely access problems. DoD developed TRICARE to solve the problems and meet the cost generated by CHAMPUS in delivering timely access to quality health care for military retirees and eligible dependents. Enrollment in TRICARE, requires co-payments and premiums based on the degree of health care coverage desired. TRICARE for Life requires Medicare-eligible beneficiaries to purchase Part B coverage and DoD serves as the supplemental insurer. All three approaches appear to be meeting the health care needs of affected patient populations.

One of the interesting observations is the effective use of "certified" coders by IHS in its third-party reimbursement efforts. Although not authorized to hire "certified" coders by the Office of Personnel Management (OPM), IHS sent selected coders to attend training to become "certified." Fortunately, these "certified" coders choose to continue with IHS even though they are underpaid based on their enhanced abilities and skills. The difference in the collection rate between coders and "certified" coders

is significant and cost-efficient. Certified coders within VA would help to increase third party reimbursement rates.

SPECIALIZED SERVICES

Most notable among the health care services provided by VA are its specialized services, especially spinal cord injury, geriatrics, prosthetics, blind rehabilitation, and long-term care. As the veterans' population ages, greater demand for these services are anticipated, particularly, long-term care. The Millennium Health Care and Benefits Act of 1999 mandated VA to provide long-term care for all veterans rated 70 percent or more service-connected. Currently, VA is not meeting the mandated inpatient bed levels also prescribed by this legislation. I did not visit a single VA long-term care program without a waiting list.

I am greatly concerned that mental health and long-term care inpatient beds are not included in the current CARES "market plans" developed by each VA medical facility. Ignoring these services does not diminish demand by veterans with Alzheimer's or dementia. Mr. Chairman and Members of the Committee, these veterans answered the nation's call to national service—it is time for the Nation to answer their calls for assistance.

STAFFING SHORTAGES

The VA health care system is blessed with many dedicated employees—both health care providers as well as the support staff. The former Secretary Jesse Brown may have officially coined the phrase Putting Veterans First, but most VA employees institutionalized the concept decades earlier. Unfortunately, VA has failed tremendously in the recruitment of health care professionals and other support positions. Nearly every VA medical facility expressed staffing shortages stemming from one of three sources—normal staffing shortages, inadequate salaries, and the Federalization of Guard and Reserve personnel in support of the War on Terrorism and Operation Iraqi Freedom.

Additionally, medical research must be funded at levels adequate to continue VA's long tradition of ground breaking medical advances. The research opportunities available through VA continue to be a strong incentive to attract health care professionals.

A serious review of performance standards, compensation, and actual work performed by "part-time" physicians is desperately needed. During my visits, I learned of a serious problem with some "part-time" physicians receiving compensation, but performing no services. This is absolutely unacceptable and does not reflect favorably on the medical facility director or those responsible for monitoring employees' attendance and performance of duties. At a time of lengthy waiting periods for primary care and specialized care appointments, the unauthorized absence of "part-time" health care providers is inexcusable. It would seem timesheets and work schedules should document work performance before paychecks are released. There must be a better tracking system to monitor and evaluate the job performance of "part-time" physicians.

ORGANIZATIONAL STRUCTURE

While visiting VA medical facilities, I noticed a change in management styles and philosophies from one VISN to the next. It seemed as though there were 21 distinct VA systems instead of one. The effort to decentralize the management and leadership of VA appears to have created inconsistencies in focus and conflicting policies and directives. Unilateral actions by individual VISN directors do not improve the system as a whole and seem to lack coordination of efforts. Clearly, subjective budgetary decisions have taken their toll on some VA medical systems to efficiently meet the needs of the local patient population. The most obvious example is the loss of inpatient beds for specialized services such as mental health and long-term care. Some MCCF collection practices are clearly more successful than others. Management efficiencies also cover the spectrum, but do not reflect a unified VA system. Performance standards seem to vary from VISN to VISN.

MEDICAL SCHOOL AFFILIATIONS

Currently, there are 126 accredited medical schools in the United States. VA Medical Centers (VAMC) have formal affiliations with 107 of these medical schools and some 1,200 other educational institutions. The value of medical school affiliations to the national health care system has been well demonstrated. VA provides critical clinical settings for physician trainees. The high level of care provided by VA medical facilities is the result, in part, of numerous external accrediting agencies and

the supervision of residents who consider the educational role as a critical component of their VA duties.

Medical research is yet another large component of medical school affiliations. Staff physicians affiliated with medical schools customarily hold academic positions, including tenured positions, provide direct patient care, teach students, advise residents, and conduct research—all of which contribute to excellence in a teaching hospital environment.

CAPITAL ASSETS REALIGNMENT FOR ENHANCED SERVICES (CARES)

CARES remains a major topic of concern in every VA community I visited. The fear of the unknown spawned the question, "Do you think they will close this facility?" This uncertainty causes anxiety among health care providers, medical researchers, patients, and support staff. The individual marketing plans are being carefully crafted to meet the anticipated health care needs of the local veterans' community, but are being altered by external guidelines from the VA Central Office in Washington, D.C. Recently, the VA Central Office returned local marketing plans of some 20 medical facilities for additional review. This seems inconsistent with the intent of having locally generated marketing plans developed to meet the health care needs of their patient population.

As National Commander, I created The Veterans Affairs Facility Advisory Committee on CARES (VAFACC) to The American Legion's Veterans Affairs and Rehabilitation Commission. The committee's charge was to review the VISN Market Plans, Planning Initiatives, and VA Facility Assessment Reports relating to the CARES process, keeping in mind VISN's were tasked to cut 10 percent of their vacant space by 2004 and 30 percent by 2005.

The VAFACC developed an independent assessment of the facility recommendations resulting from the CARES process. The committee was composed of experts in the fields of construction, engineering, veterans' benefits, medical school affiliations, health care policy, health care delivery, and health care administration.

Committee members reviewed each Market Plan and Planning Initiative submitted to the National CARES Planning Office (NCPO) for each of the 20 VISN's going through Phase II of CARES.

After a thorough review of the proposed Market Plans, the VAFACC raised the following concerns:

• *Funding.*—Clearly, billions of dollars in discretionary appropriations will be needed to accomplish the new construction and renovations approved in the final CARES plan. CARES is an ongoing process and incremental changes are anticipated. With the proposed consolidations and transferring of services, it is imperative that no veteran experience any delays in timely access to the delivery of quality health care, and patient safety must not diminish. No VA medical facilities should be closed, sold, transferred or downsized until the proposed movement of services is complete and veterans are being treated in the new locations. Funding levels should be adequate to ensure services are available during periods of transition.

• *Veterans' Population.*—There is some concern that the projected veterans' population is underestimated. Certainly with regard to long-term care, mental health, domiciliary, and other specialized care populations, the CARES process has yet to incorporate projections.

• *Long-Term Care.*—VA spent close to $3.3 billion on long-term care in fiscal year (FY) 2002. With the enactment of the Millennium Health Care Act, demand will most likely increase due to the aging of the veteran population over the next decade. VA estimates that the number of veterans most in need of long-term care, those veterans 85 and older, will more than double to about 1.3 million in 2012. Yet, even with these numbers, veterans' long-term care needs and projected growing demand was omitted from the CARES process.

• *Mental Health.*—Due to several factors concerning the initial projections, NCPO and several other experts are reviewing the mental-health inpatient and outpatient projections. Because of the questionable demand decline in several markets, networks were instructed to plan for increases in mental-health services only. VA must include accurate mental health projections in order to ensure effective recommendations from the CARES process.

• *Domiciliary.*—The inappropriate distribution of domiciliary beds based on demand projections gave rise to several policy and programmatic concerns and questions. Because the original projections were based upon a national average utilization rate, the model redistributed beds from existing domiciliaries to areas where there are none. For those reasons, further study is needed and projections must be revised before the next planning cycle.

• *Unutilized Space.*—Among the criteria the VISN's were tasked to evaluate was unutilized space. The VISN performance measure was a reduction of 10 percent by

2004 and 30 percent by 2005. According to VA's Office of Facilities Management (OFM), VA facility assets include 5,300 buildings; 150 million square feet of owned and leased space; 23,000 acres of land—the total replacement value of all elements is estimated at $38.3 billion. OFM assessed and graded 3,150 buildings for a total of 135 million square feet with correction costs estimated at $4.5 billion. These assessments were used at the local level as a tool to help manage medical centers and VISN's vacant or underutilized space.

More development is needed by the VISN's to effectively utilize unused space in lieu of selling or demolishing these buildings. Once the buildings are gone, there will be no way of getting them back. Before any unutilized space is sold, transferred, destroyed, or otherwise disposed of, the CARES process must consider alternative uses of that space to include: services for homeless veterans, long-term care, and the expansion of existing services to alleviate the extreme backlog of patients waiting to receive care at many VA medical facilities. Such considerations were lacking in most of the VISN Market Plans.

• *Contracting Care.*—Throughout the VA health care system, contracting out of care is very prevalent, especially the Community Based Outpatient Clinics (CBOC's). While contracting out of care is necessary in some circumstances, the wholesale use of this health care delivery tool should be exercised with caution. In certain areas, it will be difficult at best based on availability of approved medical staffing and the contract fee schedules.

Contracting out of care was extensive in the VISN proposals. Some VISN's made the blanket statement that care would be contracted out to meet excess demand in 2012 and 2022. That is not much of a plan. What if the resources are not available? Additionally, VA's history with contracting is not enviable. VISN 10 proposed contracting with local providers/hospitals for inpatient beds to bring their access standards from the current 32 percent to 83 percent in 2012. That is an enormous gap to cover through contracted care. VISN 6 proposed 19 new CBOC's. VA-wide, there are more than 130 new CBOC's planned to enhance access to care.

• *Enhanced Use Lease Agreements.*—With Enhanced Use Lease Agreements (EU) VA can maximize return from property that is not being fully utilized. EU leases also allow VA to reduce or eliminate facility development and maintenance costs. Through the use of EU leases, VA can receive cash or "in-kind" consideration (such as facilities, services goods, or equipment).

Several of the VISN's proposed enhanced use lease agreements with the public and private sectors. Uses include homeless shelters or housing, cultural arts centers, cemeteries, inpatient beds, mental health services and many other veterans' service enhancing ideas.

VA should continue to seek opportunities in the area of enhanced use leasing. It can certainly have a positive impact on service delivery to veterans and the local community.

There have been 27 projects awarded so far. The VA Secretary has 23 on the priority list with over 50 more currently in development. Clearly, VA is continuing to urge the VISN's to consider using this valuable tool even more. However, the committee recognizes that the approval process involved in obtaining an enhanced use lease is lengthy and complex.

• *VA/DoD Sharing.*—There are many opportunities for sharing between VA and the Department of Defense (DoD). The VISN Market Plans contain many proposals addressing the possibility of service sharing to increase access to health care for veterans. Both VA and DoD benefit from these agreements and every effort should be made by the VISN's to pursue this avenue in order to save money through cost avoidance, in particular pharmaceuticals, supplies and maintenance services.

Extra effort on the part of these agencies to cooperate is essential to the success of sharing agreements. Some parts of the country are reluctant to "share" services or programs between agencies. It is imperative that we overcome that obstacle and look to the future of providing quality health care and reasonable access to this nation's veterans.

The American Legion will remain an active partner with VA during this critical process of realigning the agency's capital assets to better serve America's veterans. Recent developments in the CARES process serve to reinforce some of my concerns. The Under Secretary for Health has sent back the Market Plans to 15 VISNs/20 facilities with instructions to further develop other options and look at further consolidating inpatient services in many of the facilities. Additionally, the CARES Commission hearings have been postponed until August 2003, another 60 days. Delays such as these give rise to many questions and concerns on the part of the stakeholders.

RECOMMENDATIONS

Capital Asset Realignment For Enhanced Services (CARES).—The American Legion recommends an open and transparent process that continually and fully informs VSO's of CARES initiatives, criteria, proposals and timeframes. Any CARES recommendations should be considered in the context of a fully utilized VA health care delivery system that takes into consideration the tenets of the GI Bill of Health, VA/DoD sharing, the Veterans Millennium Health Care and Benefit Act and the mission of the Department of Homeland Security. VA must also provide a list of capital assets to the Department of Homeland Security for consideration in strategic planning at the local, state, and national level.

Medicare Reimbursement.—The American Legion recommends Medicare Reimbursement for VA on a fee-for-service basis for the treatment of nonservice-connected medical conditions of enrolled, Medicare-eligible veterans. Additionally, veterans should be authorized to participate in the Medicare + Choice option by choosing VA as their primary health care provider.

Medical School Affiliations.—The American Legion supports the mutually beneficial affiliations between VA and the medical schools of this nation. The American Legion also recommends appropriate representation of VA Medical School affiliates as stakeholders on any national task force, commission, or committee established to deliberate on veterans' health care.

Mandatory Funding for VA Medical Care.—The American Legion recommends that Congress designate VA medical care as mandatory spending and provide discretionary funding required to fully operate other programs within VHA's budgetary restrictions. Additionally, Congress should provide supplemental appropriations for budgetary shortfalls in VHA's mandatory and discretionary appropriations to meet the health care needs of America's veterans.

Expanded Third-Party Reimbursement.—The American Legion recommends the following to improve accessibility to VA health care and expand third party reimbursement:

- All enrolled veterans would be required to identify their public/private health insurers.
- VA would be authorized as a Medicare provider and be permitted to bill, collect and retain all or some defined portion of third-party reimbursements from CMS for the treatment of non-service-connected medical conditions.
- VA should be authorized to offer a premium-based health insurance policy to any enrolled veteran having no public/private health insurance.
- All enrolled veterans would be required to make co-payments for the treatment of non-service connected medical conditions and prescriptions.
- All enrolled veterans with no public/private health insurance would agree to make co-payments for treatment of non-service connected medical conditions.

SUMMARY

The history of the veterans' health care system is a lengthy story of evolution. Although its mission is simply stated in President Lincoln's Second Inaugural Address—to care for him who shall have borne the battle, his widow and his orphan—financial obligation toward meeting that mission continues to lag. VA has never faced a shortage of patients, but has always endured financial pressures. From the beginning, VA was open to any veteran in need, until the 1980s when Congress enacted legislation that divided veterans into three groups—service-connected veterans, economically indigent veterans, and all other veterans. For the first time, honorable military service wasn't enough to qualify a veteran for access to a VA medical facility.

From the founding of this great country to the present, America has recognized its obligation to the men and women of the armed forces—past, present, and future. As a grateful nation, providing timely access to quality health care, transitional assistance from military service to civilian life, timely adjudication of disability claims, and a final resting place continue to be a moral, ethical, and legal obligation.

Recently, new terms like "core veterans" and "traditional users" have been used to serve as justification for America's failure to meet the health care needs of its veterans. Yet, neither term appears in Title 38, United States Code. Such terms appear only in the minds of bureaucrats. Veterans' status has always had a direct correlation to honorable military service. A veteran is a veteran. So why has Congress and VA chosen to place veterans in separate priority groups? How could service-connected veterans in Priority Group 8 be denied enrollment in the VA health care system, when nonservice-connected veterans in Priority Group 7 can enroll? Neither Social Security nor Medicare places beneficiaries in priority groups, so why are veterans treated differently?

Neither Social Security nor Medicare has limitations placed on beneficiaries like Priority Group 8 veterans based solely on means testing or the HUD geographic index. Why the inequity?

Granted financial contributions are normally made to both Social Security and Medicare throughout a beneficiary's working life, but few Americans (less than 10 percent) make a personal commitment toward national security as do veterans. If Social Security and Medicare beneficiaries are "guaranteed" funding or "guaranteed" timely access to medical care, why are veterans treated differently?

It seems entitlement to Social Security benefits and Medicare coverage is unquestioned by Congress. Yet, a veteran's entitlement to timely access to health care—even for those willing to pay—is always being questioned, budget year after budget year.

There seems to be a misconception among certain groups that designating VA Medical Care as a mandatory funding item within the Federal Budget would provide free health care for all veterans. This is not true. Mandatory Funding for VA Medical Care will provide a more accurate mechanism for funding VA Medical Care at a level that will ensure VA has the ability to serve all eligible veterans and to meet it's self-imposed access standards—30 days for a primary care appointment, 30 days for a specialty care appointment and an average wait time of 20 minutes to be seen by a VA physician.

Years of under-funding have created the current crisis in VA health care. Budgetary constraints have led to staffing shortages, elimination of services and unmet demand for care. Rationing health care by denying access to Priority Group 8 veterans is not the answer. Charging an annual enrollment fee for certain Priority Groups is not the answer. Raising co-payments for outpatient services is not the answer. Raising co-payments for prescriptions is not the answer. Designating VA Medical Care as a mandatory funding item within the Federal Budget is a solid step toward improving accessibility of health care for all veterans and The American Legion fully supports this.

Mr. Chairman, veterans have served, are serving, and will continue to serve this Nation in an uncharacteristic manner—putting duty, honor, and country before self. Many national leaders have issued the challenge for Americans to serve this Nation as a member of the Armed Forces, both on active-duty and in the Reserve components. Fortunately, every day men and women freely accept that challenge.

If America can find the money to bail out failed savings and loans institutions, commit troops to peacekeeping missions, rebuild foreign governments, provide health care for Third World countries, and forgive loans to foreign countries, then, surely, America can find the money to provide the needed care for America's veterans. This is what veterans want, and I believe it is what America believes is right. Those same soldiers, sailors, airmen, and Marines securing the safety of foreign citizens may one day turn to VA for their health care needs. I am committed to ensuring that those brave men and women have a VA that can provide the care they need.

Not far from here are the acres of white headstones at Arlington National Cemetery that serve as a constant reminder that the cost of freedom is a recurring debt paid every day by men and women in uniform. Each headstone represents a debt that can never be repaid. We honor those men and women by caring for their comrades. This is something that no one disputes, yet is it also something that we as a Nation can do better—we will do better—we must do better.

Mr. Chairman and Members of the Committee, that concludes my testimony. I ask that an electronic version of the final report be included in the record.

Chairman SPECTER. Commander Conley, your voice sounded fine, and your testimony was profound, and we thank you for it. The special report by Commander Conley, "A System Worth Saving," will be included in the record as requested.

To repeat, we are very proud of you in Pennsylvania, our State, Ron, for the prodigious service you have performed, but all of America is proud of you. Veterans are indebted to you for your very comprehensive report.

I note that your comments have been reported in a Pittsburgh Post Gazette article by Jack Kelley in today's paper and by Suzanna Rosenblatt, Los Angeles Times staff writer. We will include both of those reports as well, summarizing the testimony.

A System Worth Saving

A SPECIAL REPORT

on the condition of VA Health Care in America

Ronald F. Conley
National Commander

THE AMERICAN LEGION

Executive Report: A System Worth Saving

By Ronald F. Conley
National Commander
The American Legion

"With malice toward none, with charity for all, with firmness in the right as God gives us to see the right, let us strive on to finish the work we are in, to bind up the nation's wounds, to care for him who shall have borne the battle and for his widow and his orphan, to do all which may achieve and cherish a just and lasting peace among ourselves and with all nations."

— Abraham Lincoln, March 4, 1865

President Lincoln's second inaugural address put into words a deeply held American conviction, a value destined to resonate across the decades – that those whose lives are altered by military service uniquely deserve the public's care long after the guns fall silent. Such care is the reward for assuming a responsibility that can, at any given moment, take your life, or some piece of it.

"The term 'veteran' means a person who served in the active military, naval, or air service, and who was discharged or released therefrom under conditions other than dishonorable."

— U.S. Code, Title 38, Sec. 101

In 1959, Lincoln's phrase "to care for him who shall have borne the battle" became the official motto of what was then the Veterans Administration. The VA administrator of the time, the hard-driving Sumner G. Whittier, had the words engraved onto plaques that were attached to the front entrance of the agency's national headquarters in Washington. In the days before forgettable mission statements replaced oft-quoted mottos, there was no question who the VA worked for, or why.

Today, so much has changed. The Veterans Administration is now the Department of Veterans Affairs. It is no longer an agency tasked with providing services of last resort,

or on an as-needed basis, for the sick, disabled, weary and poor who once served our country in uniform. It is a Cabinet-level department whose duty is to repay a grateful nation's debt to freedom, to cover the delayed cost of war. That cost includes fair compensation and benefits, as authorized by Congress and the President, for *all* men and women whose lives the government once risked to protect national interests. Rich or poor, disabled or not, from Florida or from Alaska, the risk was the same. A veteran is a veteran. Anyone who raised an M-16 in basic training, ran five miles in boots and packs, rappelled from a helicopter into an ocean, or discovered firsthand what it means to "fix bayonets" meets the criteria set forth in U.S. Code, Title 38, Section 101, as long as discharge was not dishonorable. The private who peeled potatoes in Korea. The seaman who swabbed the deck aboard ship in the Persian Gulf. The chaplain who delivered last rites to men ripped in half by machine-gun fire in Vietnam. The airman who spent four years in a bamboo cage. The computer specialist who saved lives on battlefields 5,000 miles away.

"We can't offer veterans the health care they deserve while simultaneously cutting the VA budget to the bone."

— Sen. Jay Rockefeller, D-W. Va., 1994

They all are veterans.

Whether they came home whole or not, they all came home changed by the experience. These are today's users of the VA health-care system – a broad demographic cross-section of men and women who sacrificed some part of themselves for America.

As National Commander of the 2.7-million-member American Legion, the nation's largest veterans service organization, I represent them all. And their welfare is the very purpose of the Department of Veterans Affairs.

This report on the current VA health-care crisis was guided both by duty and privilege. It has been my honor to meet firsthand so many talented people who fulfill our government's health-care obligations to veterans. I investigated more than 50 VA facilities throughout America in the past nine months, and the following remarks, observations and recommendations are based on discoveries I made and information provided to me

along the way.

In touring these facilities, I did not stay with the group. I compared boardroom pronouncements from administrators and public-affairs staff with the unabashed opinions of hard-working doctors, nurses and technicians on the front lines. Of course, I also spoke with thousands of veterans and their families who entrust their lives to this system. Among VA employees, I witnessed examples of dedication, professionalism, safety recognition and resourcefulness. Among veterans, I heard profound gratitude voiced for the quality of care they receive.

But from nearly everyone, I also found acute frustration about the lack of timely access to VA health care, under-use of some facilities, overcrowding in others, and inconsistent budgets and budget expectations. The portrait is vivid. America's excellent VA health-care system – a paragon of quality in so many ways – is being consumed by fiscal neglect. It is my duty as a leader of veterans to share that portrait with those who have the power to change it and to lay out what I found before a public that is largely unaware a problem even exists. It has been an eye-opening journey.

"Veterans were promised by the Federal Government that for their service to the country they would be provided a lifetime of health care services, as well as their own health care service network."

— H.B. 890, 21st Century Veterans Equitable Treatment Act, introduced Feb. 25, 2003

My first stop was Dallas, Texas, last Sept. 20, where I gazed down the dark, dreary corridor of a long-term care facility and wondered, quite honestly, if I had been dropped off somewhere in the 1940s. There, I found the first in a long line of facilities where capital improvements have been shelved for the sake of hitting a bottom line. At Bay Pines, Fla., I encountered a VA Medical Center where the list of veterans waiting six months or longer for primary-care appointments *had been reduced* to 14,000. At Prescott, Ariz., no one knew how many registered nurses worked in the hospital or how many new veterans were enrolling each month; I later learned that particular facility, where patient numbers have more than doubled since 1997, is on the chopping block. Conversely, in Salisbury,

N.C., the director said 75 new doctors and $17 million are coming soon to solve that medical center's five-figure backlog. Why there? And where was this money coming from? The director said he didn't know, but he was sure it was coming. In Cheyenne, Wyo., the hospital director explained that his patient load had risen from 6,000 to 13,000 in the same period that his staff numbers had dwindled from 385 to 340. A director in Louisville, Ky., said the VA hospital under his supervision simply needs to be torn down and rebuilt; one emergency-room doctor there can expect to treat 50 or more veterans a day. And a director in Manchester, N.H., said veterans would be better-served in non-VA facilities.

"VA health care has been a well-kept secret for many years. Our goal through this new education campaign is to inform each and every veteran living in Maryland about their eligibility for VA health care and what we can do to assist them."

— Dennis H. Smith, Director, VA Maryland Health Care System

Throughout America, it is obvious VA health-care operations are trying to do more with less. Demand has soared, and funding has failed miserably to keep up. Staff shortages are everywhere. Those shortages close beds, wards, emergency rooms, nursing homes and intensive-care units. The shortages force the patients for whom these facilities were built to be turned away. Shortages force the VA secretary to unravel the clear intent of the Veterans Health Care Eligibility Reform Act of 1996 by once again restricting enrollment only to the poorest and sickest among those who served.

To its credit, America's budget-strapped veterans' health-care system does not ration quality. Unfortunately, because the funding pie cannot be cut into enough pieces for all, VA must ration access. That is why tens of thousands of veterans are waiting in line to see doctors. Honestly, what good is high-quality care if you can't get an appointment to receive it?

Capital-improvement measures to cope with recent demand growth remain stymied until the potentially controversial CARES (Capital Asset Realignment for Enhanced Services) recommendations are unveiled. At Roudebush VA Medical Center in Indianapolis, the director reported his facilities must expand immediately to handle the

current patient load and to accommodate all the projected growth. "We are in desperate need of additional clinic space," the director answered on a questionnaire I submitted before my visit. "On our best days, we can make available an average of 1.3 exam rooms per provider when the local standard is two per provider ... At times there is not even one exam room per provider in the clinic. We have plans to expand, but this will be an ongoing issue."

Meanwhile, VA facility directors in other parts of the country are quietly gobbling up their capital-improvement reserves to handle day-to-day operating costs. The money has to come from somewhere.

Affiliations with medical colleges and nursing schools provide essential staff support at dozens of VA facilities. Ninety percent of the doctors at the VA Connecticut Health Care System in West Haven, Conn., are affiliated with Yale University. The University of Pennsylvania medical school runs the Philadelphia VAMC emergency room every night. The University of South Carolina School of Medicine, a national leader in colorectal cancer research, shares the same campus as the VA Medical Center in Columbia, S.C.; on any given day, 50 or more university physicians and interns work in that VA facility. One VA medical center reported having affiliations with 68 different institutions of health-care education.

"I am directing each network director to ensure that no marketing activities to enroll new veterans occur within your networks."

— Laura Miller, Department of Veterans Affairs Under Secretary

But when VA facilities are downsized out of proximity to their med-school partners, those relationships are gone forever. This is happening right now in Chicago, where Lakeside VA Medical Center is merging with its sister facility on the other side of town, effectively dissolving VA's long and successful relationship with Northwestern University Medical School. Neither the veteran stakeholders nor the university administration had a voice in that decision, which was reached by an outside consulting firm.

VA collaborations with medical schools and with the Department of Defense consistently present mutually beneficial opportunities to share costs, pool services and meet

national-security objectives. In Augusta, Ga., the Army hospital provides cardiac surgery for the VA facility, which in turn does the Army's neurosurgery. Dozens of VA facilities around the country have dynamic partnerships with military installations to perform discharge physicals, ROTC examinations and provide TRICARE services. In many locations, VA and DoD share property and facilities.

VA's role as a backup military hospital in case of troop evacuation and as a primary treatment facility in the event of biological or chemical attack, in partnership with the Department of Homeland Security, or in case of natural disaster, with the Federal Emergency Management Agency, only begin to describe the scope of the system's so-called "fourth mission." However, my investigation showed widely varying levels of preparedness for that role, attributable to the need in so many facilities to simply dedicate all available resources just to meet daily patient demand. In places like Salt Lake City, a VA decontamination training site, or Ann Arbor, Mich., where the staff is ready to administer the smallpox vaccine, it is clear the staff has dutifully prepared to face any disaster. Less clear is what would happen to all their veteran patients in the event of such a disaster or sudden need of the facility by our troops; in Columbia, S.C., the VA hospital backup is an Air Force hangar.

"We have a sacred obligation to ensure that our nation's veterans receive the honors and benefits that they have earned through their service to this nation."

— Rep. Christopher Smith, Chairman House VA Committee

One wild card that frequently affects VA-DoD collaborations is that often when the base command changes, a new agreement with the VA health-care facility must be negotiated and approved. Not only does that process consume valuable time and effort, it also adds uncertainty to long-term plans. The VA health-care system is beleaguered, from bottom to top, with such uncertainties – about partnerships, affiliations, staff recruitment, budgetable funds and, in the case of facilities destined to be downsized, uncertainties about their very existence.

Just as medical-school doctors and interns provide essential staff support in many VA health-care communities, relationships with National Guard and Reserve units can be

just as vital in others. During my visits, the war on terrorism waged on, and, of course, Operation Iraqi Freedom entered new, troop-intensive phases. As more and more reserve units were activated, I found VA facilities paying close attention to just how heavily they depend on them.

In Boise, Idaho, I was greatly puzzled about how the VA Medical Center there would function in the event of a major call-up. With a 5,000-deep waiting list and a medical staff heavily populated by National Guardsmen and Reserves, there was no doubt the facility would have to move patients out of the system if many of its staff were activated. In Wilmington, Del., I was told that a major call-up would likely close beds due to the deployment of much-needed Guard nurses. In San Juan, Puerto Rico, 60 of the facility's 234 staff members who serve in National Guard and Reserves were already activated when I visited in April. So many directors reported being short-staffed already, on all fronts – doctors, nurses, pharmacists, radiologists, medical technicians – losing even 10 or 15 percent from a facility's workforce of trained caregivers could be devastating.

"This recent practice of dividing us into categories and priorities is no more than a shell game designed to deprive deserving veterans of the health care they were promised at the time our nation needed them."

— Robert W. Spanogle, American Legion National Adjutant, commission member, the President's Task Force to Improve Health Care Delivery for our Nation's Veterans

Nearly all the strategies suggested to solve this crisis have focused on reducing access, outsourcing services or finding ways around paying the actual cost of providing care. Downsizing is not the answer to unprecedented demand. The strategy of cutting off hundreds of thousands of previously eligible veterans – those now categorized in Priority Group 8 – from enrolling in the VA system is not an acceptable response to fast-rising patient growth. The strategy of closing down hospitals and consolidating VA Medical Centers in order to sell the real estate and reduce overhead is not an acceptable response to years of inadequate funding to update facilities. The strategy of handing out vouchers and sending veterans to non-VA hospitals and nursing homes for such maladies as Post-Traumatic Stress Disorder, Gulf War Illness, spinal cord

injury, Agent Orange-related diseases or for prosthetic-limb replacement is not an acceptable response for veterans who need a health-care system designed specifically for their unique circumstances. A strategy of basing the VA health-care budget on discretionary federal funds, rather than mandating that such costs be covered – or creating a mechanism by which they can be – is both a failure and an insult to everyone whose blood has been wagered to keep this nation free.

Last January, the administrative decision to suspend new enrollment of Priority Group 8 veterans was made in the interest of stemming demand the VA health-care system could not handle, within existing appropriations. However, by cutting off that particular group – those veterans of the highest income levels – the system lost the population of patients most likely to have health-insurance policies and the ability to share in the cost of their care. I found this decision especially ironic after having heard frustration from every corner of the country about VA's expectations for third-party reimbursements.

"A mandatory funding stream ... will bring increased stability and predictability in funding the health-care system designed to meet the needs of our nation's veterans."

— Rep. Lane Evans, ranking Democrat, House VA Committee, co-sponsor of H.R. 5250

Last year in San Juan, Puerto Rico, the third-party reimbursement target was $8 million. The facility beat it by $200,000. This year, the target was doubled to $16 million, a figure their director says is at least $5 million too high. Additionally, I was told, a collection agency received 25 percent of the third-party reimbursements collected in San Juan. In Omaha, Neb., where third-party reimbursements are turned over to a collection agency after 90 days, the budget target jumped from $14 million to $18.9 million. In Anchorage, Alaska, the third-party reimbursement bar was raised from $2.8 million to $5 million – at a facility that does not have room for any veterans who are less than 50-percent service-connected disabled. In Minneapolis, the third-party reimbursement target jumped from $15.5 million to $23 million. All the pressure to hit these targets and to educate an insurance industry that has been slow to accept the idea of paying claims to

VA hospitals has added new strain to the system, forcing more and more facilities to outsource collections, but the real zinger is this: success is punished because the new, increased third-party reimbursement target comes right off the top of next year's budget. Example: In Anchorage, the director who collected $3.5 million when his target was $2.8 million got a new target of $5 million; his regular operating budget only increased from $79 million to $80 million, so in the end, he loses $500,000 in operating funds for having beaten his target by $700,000.

Third-party collection targets for VA facilities are set higher in some VISNs (Veterans Integrated Service Network), and lower in others for reasons that were never well explained to me. In Birmingham, Ala., for instance, where the total budget was $128 million, the third-party reimbursement target was set at $12 million. The facility collected $13 million. The new target was then set at $13.7 million. Compare that to Wilmington, Del., where last year's target of $3 million is now doubled to $6 million, after the facility collected $3.2 million. On similar collection performance, Birmingham's target was raised 12.4 percent while Wilmington's target went up 100 percent.

I know these numbers cannot possibly be conjured from out of thin air, but many directors I spoke with agree that it is doubtful major increases in third-party reimbursement targets can be reached this year because the population of veterans driving that revenue stream – formerly Priority Group 7s who later became Group 8s – have been removed from the equation. Third-party reimbursement targets were a consistent bone of contention with nearly every VA director I met. I can understand why. The targets have been raised dramatically – doubled in some cases – an amount VA subtracts from the following year's operating allocation. The result of beating the target is often a substantially higher one the following year. And now, the population of veterans most likely to generate third-party reimbursements has been cut out of the system. Among the many challenges facing VA directors I met, increases in third-party reimbursement targets may well be the most consistently frustrating for them.

That's because no matter what happens with third-party reimbursements, these

directors know they have a much bigger fiscal problem: the vast mismatch between funding and demand. Scarcity of budget dollars inherently creates competition among VA facilities, and inconsistent veteran care is the result. How else can you explain shortage-based backlogs of 10,000 or more patients (Bay Pines, Fla.) less than 750 miles away from facilities that boast next-day service (Jackson, Miss.)? A mandatory appropriation model for VA health care – just like Social Security and Medicare – is the route we must travel to solve this problem once and for all. Funds must be allocated on a cost-per-enrolled-veteran basis, indexed annually for inflation.

Does that mean free health care for all veterans?

No, it does not.

It means all veterans with the ability to use their insurance, including Medicare, should be free to choose VA facilities for their health care, regardless of economic status or level of service-connected disability; they could be required to reveal any insurance coverage they have and make reasonable copayments for treatment of conditions unrelated to their military service. For those veterans who don't have health insurance, VA can offer a premium-based health-care benefits package. Indian Health Services, which is just as much a federal entity as VA, is authorized to bill for reimbursement from Medicare, an option that currently does not exist for VA facilities.

In essence, my entire year has been spent collecting examples of the many ways in which the discretionary-appropriations model fails to fulfill the care-giving purposes of VA. I am now convinced that anything less than a mandatory funding model is a guarantee that veterans, their service organizations, congressional committees and VA officials will continue visiting and revisiting this issue until they realize that 30-percent increases in demand cannot be served by 7-percent increases of funds. All the commissions, task forces, committees and panels in America can debate the details and dream up new ways to cut corners for years on end, but there's one prevailing reason for this health-care crisis. That reason is the funding formula.

Evidence of the funding problem is the most glaring consistency across the system.

Inadequate resources plague every facility in every VISN. Even in the best-endowed facilities, such as those in the Puget Sound area in and around Seattle, Wash., where the annual budget is $296 million and outside research dollars account for more than $400 million more, a shortage of nurses there means the intensive-care unit cannot always function. And although research money represents the largest piece of that system's revenue pie, facilities there remain more than 50,000 square feet short of having sufficient space for the research their grants require them to perform. To make ends meet, like so many facilities across the country, Puget Sound digs into its capital-improvement reserves.

In Omaha, Neb., for the past two years, two-thirds of the capital-investment fund has been exhausted to cover operating costs. This year, the director there hopes the capital reserves only dwindle by half in order to meet regular expenses. In Ann Arbor, Mich., use of capital-investment money to balance the budget is a foregone conclusion; unfortunately, the director there projects a $7 million deficit anyway.

However, the shortest route between deficit and surplus at any VA facility runs straight through payroll. That's why there are staff shortages everywhere.

In Cheyenne, Wyo., the hospital director, a doctor himself, treats patients alongside the physicians under his supervision. That facility, where demand has more than doubled while staffing has decreased by over 10 percent, must routinely shuffle patients from floor to floor to put veterans into proximity of caregivers. There, they are forced to perform the kind of triage one might expect on a battlefield, but not in a VA hospital. At Edward Hines Jr. VA Hospital in Hines, Ill., there are seven vacancies for spinal-cord specialists, despite finder's fees and signing bonuses. In many locations, VA facilities are forced by urgent demand to fill in with agency-contracted nurses, part-time doctors and short-term foreign physicians looking to fulfill the minimum requirements of their J1 visa obligations so they can start practices elsewhere. VA has been forced to rely on short-term and contract arrangements more and more to cover increased patient numbers. When I visited the Bay Pines, Fla., medical center in October 2002, the federal budget

was still hung up in Congress. The director there reported on my questionnaire: "At present, we have no '03 budget and are operating at '02 levels, under the existing continuing resolution. Continuing resolutions are very destructive with respect to any planning activities. Based on current information, it is quite possible we would operate under a continuing resolution for the next four or five months, which represents a significant challenge as we attempt to deal with medical inflation, pay raises and increasing workload."

Nearly every facility I visited reported that the only way they can hire and retain pharmacists is by restructuring salary scales. A director in Birmingham, Ala., explained that it's impossible to keep up with the private sector when a pharmacist in Atlanta, Ga., can receive a free Mercedes-Benz as a signing bonus. In California, they get BMWs. In the VA system, they're lucky to get competitive pay. In Lexington, Ky., I was informed that a pharmacist who works in the back of a local grocery store or chain retailer can expect $20,000 more a year than a VA pharmacist.

Every ward I visited at Bay Pines – one of the largest VA facilities in the nation – suffered from a nursing shortage. Some wards reported only two registered nurses for every 32 patients. In Knoxville, Iowa, I was informed that nurses there were required to work 40 hours of overtime a month, and it was not uncommon during night shifts for one nurse to handle two wards – up to 52 patients – alone.

They're short-staffed and working overtime in Hampton, Va. They're short-staffed, working mandatory overtime and closing beds in Lexington, Ky. They're short-staffed and calling in retired nurses part-time in Augusta, Ga., and in Boise, Idaho. They need 20 more nurses in Jackson, Miss., but don't have the budget to bring them in. At Hunter Holmes McGuire VA Medical Center in Richmond, Va., $10,000 signing bonuses are paid for nurses who are so difficult to recruit and hire that only 277 of the facility's 427 authorized beds are available for patients – this at a facility where more than 2,000 veterans wait six months or longer to see a doctor, and it's not uncommon for a veteran to sit in the waiting room six hours for an eye appointment.

A facility in Mississippi pays $350,000 a year for contracted orthopedic surgery services when $185,000 would put such a surgeon on the payroll. In Tucson, Ariz., the director said he was paying $500,000 a year for similar specialized care that could be purchased for $300,000 less by hiring a staff doctor. The only explanation I can understand for such decisionmaking is that facility directors do not know one year to the next if their budgets will cover a regular payroll commitment. And when the federal budget is hung up, as was the case last year, VA directors have no confidence to make longterm payroll commitments of any kind; they bring in subcontractors at higher rates instead. And those facilities that are subject to CARES downsizing certainly are not in a position to offer secure commitments.

All these adversities connect to the central problem: a discretionary funding formula that, by its cyclical nature, does not allow for the execution of long-term plans. It becomes a system of triage, a system where veterans are pouring out of waiting rooms and appointment books are filled up six months, a year, even two years out.

Everywhere in the system, veterans are waiting, waiting, waiting. Some worry that they will die before they get in to see a doctor. Ernest A. Masche of Hickory, N.C., expressed his frustration this way: "I applied for VA health care in March 2002. On Aug. 23, I received a letter stating I had been accepted and placed in Priority Group 5. I have been waiting since then for a primary-care appointment. I recently contacted VA and asked what is taking so long. 'Everyone's waiting,' I was informed. 'When your number is picked, you'll get a call.' My wife and I are on a fixed income ... I served because I love my country. I've never asked for a thing but this one time. I'm afraid I might die before help arrives."

Many veterans have lost hope. They are disillusioned and feel betrayed. Ernesto A. Tafoya of Pueblo, Colo., says he never believed the government owed him anything, "but when I signed up for the military, the government said they'd take care of me. They've been telling us that for 60 years. They haven't followed through yet, and it doesn't seem like they're going to."

VA facilities so often have to seek outside contractors to follow through on their most urgent responsibilities. When the patient backlog broke 10,000 in Portland, Ore., VA contracted outside providers to care for 4,500 of them. All of the long-term care and Alzheimer's/dementia cases are contracted out at the Birmingham, Ala., VA Medical Center. Frequently throughout the nation, I found VA contracting with states for nursing-home care. At the VAMC in Anchorage, Alaska, approximately half the budget is spent on contracted services, and any veteran who needs specialty care is flown to Seattle. If not for outside contractors, medical-school physicians, J1 visa doctors, National Guard and Reserve health-care providers and DoD support, VA would have an extremely difficult time functioning in most parts of the country.

At some facilities, long-term care and mental health treatment are inter-mingled, due in no small part to a lack of resources to create and maintain separate programs. In most facilities, patients who suffer from Alzheimer's disease – with the serious level of attention it requires – share space with the regular nursing-home population or with those who suffer from other forms of mental illness. Some facilities have excellent programs in these areas. Others outsource it completely. Some make no attempt. Such inconsistencies exist because VA directors don't have enough resources from the government to deliver care in balanced measurements.

And yet, funding always seems readily available in billions for foreign aid, millions for pork-barrel projects that range from restoring statues of mythological gods to subsidizing Elvis impersonators who perform weddings aboard airplanes, and there's always enough to keep sending young men and women off to foreign lands in defense of our freedoms, or for those of other nations. If history tells us nothing else about veterans, we know America will keep producing them.

And when the U.S. government issued orders for soldiers, sailors, airmen, Marines or Coast Guardsmen to deploy, the clause "within existing appropriations" was never mentioned. There were no 14-month scheduling delays. When the call came, veterans stepped up. Now that the roles have been reversed, it's a different story. Army veteran

Ahnighto E. Riddick of Elizabeth City, N.C., was informed by the Department of Defense that his unit had been exposed to nerve agents during Operation Desert Storm and was told to immediately contact VA for help. Immediately, he was put on a two-year waiting list for a primary-care appointment. "I'm frustrated because I gave my country loyal service," the veteran explained. "Uncle Sam has turned his back on us."

A veteran from Joplin, Mo., must travel 255 miles one way to the Harry S. Truman Memorial Veterans VA Hospital in Columbia, Mo., because no VA facility nearer can treat his diabetes. In Salisbury, N.C., diabetes care represents about 18 percent of the patient load and consumes $16 million of that facility's $135 million annual budget. At Little Rock, Ark., the line for the MRI machine is 1,000 veterans long. In Charleston, S.C., the CARES market plan recommends a 100-percent increase in square footage. In Spokane, Wash., there are eight beds for the 2,800 unique mental-health patients served there. And the reason for closing down Lakeside VA Medical Center in Chicago, as far as I can see, has nothing to do with Abraham Lincoln's words, does not fulfill the government's obligation one bit. In fact, it stinks.

The words of a veteran who responded to The American Legion's "I Am Not a Number" campaign last year keep rolling over and over in my mind. "I spent 27 months of my life in that hell-hole called Korea and this is the best my government can do for me?"

I think not.

The Department of Veterans Affairs is America's biggest managed-care system. It is a national treasure. Access to it is a good reason for any young man or woman to serve in the U.S. Armed Forces. This health-care system was created because the health-care needs of veterans are unique, and the U.S. government has an inviolate responsibility to see to it those needs are fulfilled. That is why VA has 162 hospitals, 850 clinics, 137 nursing homes and 43 domiciliaries designed to serve veterans. The existence of this program stands as profound evidence of our nation's gratitude to those "who shall have borne the battle." Call it a debt. Call it an obligation. Call it a promise. The VA health-care system exists because it is woven into our national value system. It exists because tens of thousands of men and women were willing to give their lives for the freedom of all others who make America their home. That is why it is a system worth saving.

Consolidated Site Visit Report

The following material represents a summarization of information provided to American Legion National Commander Ronald F. Conley during site visits to VA health-care facilities throughout the nation during the past nine months. Some facilities were better-prepared than others to provide consistent, relevant information, herein current at the time the visits were made. The following report, broken down by facility, is condensed from a collection of larger reports, available through The American Legion's Veterans Affairs & Rehabilitation Division in Washington, D.C.

North Texas VA Health Care Medical Center
Dallas, Texas
Sept. 20, 2002

Demand and Delay: 130 beds operating at 80-percent capacity. Parking is limited. The campus used to be much larger than its current 85 acres, but VA gave the property to the Dallas Independent School District free of charge. Now the Dallas VAMC leases a portion of that same property back from the school district, for parking. Demand has grown 16 percent while the budget has grown 5 percent.

Funding: Budget was $15 million short. Third-party reimbursements generated $16 million; the target for 2002 was increased to $20 million, and Dallas VAMC collected $23 million of which $3 million went to reduce the operating deficit.

Long-term care/mental health/homeless: Mental health represents 18 percent of the workload – approximately 11,000 mental-health patients in the hospital and another 2,500 outside. The main facility was built more than 70 years ago and is inadequate to meet the needs of veterans seeking mental-health care. Plans for developing a new mental-health care hospital have been on the books for a couple of years – five stories at a cost of about $33 million today when, if done when the need was first identified would have been $19 million. The cost continues to rise as physical improvements are stalled in the CARES process.

Bay Pines VA Medical Center
St. Petersburg, Fla.
Oct. 19, 2002

Demand and Delay: The backlog of patients waiting for a primary-care appointment is 14,000. One-hundred new veterans apply each month.

Funding: They are currently collecting $32 million to $36 million in third-party reimbursements.

Affiliations/partnerships: University of South Florida Medical School.

Staff shortage: Extremely short on nurses.

Emergency room: One ER doctor treats 60 to 70 veterans a day.

Long-term care/mental health/homeless: They offer three psychiatric-care programs. They have 104 domiciliary beds, 25 of which are used for homeless veterans. Women veterans seeking psychiatric care must wait up to four months for an appointment.

Togus VA Medical/Regional Office Center
Augusta, Maine
Oct. 21, 2002

Demand and Delay: 5,400 new veterans must wait more than a year for initial primary-care appointments. Another 1,800 still waiting to be enrolled.

Funding: $90 million operating budget, including $2.8 million from third-party reimbursements.

Staff shortage: Shortage of staff, especially LPNs.

Long-term care/mental health/homeless: Long-term care, dementia, Alzheimer's and psychiatric beds total 100. Togus is in need of a long-term psychiatric unit.

Hunter Holmes McGuire VA Medical Center
Richmond, Va.
Nov. 1, 2002

Demand and Delay: More than 2,100 veterans are waiting more than 30 days for primary-care appointments. New patients are waiting six to seven months for primary-care appointments. The wait at the eye clinic is six hours.

Affiliations/partnerships: They have an agreement with the local medical college.

DoD sharing: Agreement with DoD to serve as backup to local military health-care facilities. VA provides spinal cord care for DoD beneficiaries.

Staff shortages: They are in need of nurses. They are offering $10,000 bonuses for specialty-care nurses. They operate only 277 of the authorized 427 beds due to staff shortages.

Long-term care/mental health/homeless: Geriatric primary care can only operate 70 of the 98 authorized beds due to the nursing shortage.

Fourth Mission: They are involved with DoD on homeland security planning.

Hampton VA Medical Center
Hampton, Va.
Nov. 2, 2002

Demand and Delay: 2,492 veterans waiting longer than 30 days for treatment. The hospital is closed, except for the emergency room.

Affiliations/partnerships: Sharing agreement with DoD.

Staff shortage: Short staffed and working overtime.

Long-term care/mental health/homeless: The substance-abuse and homeless-care areas of the facility were dirty. Staff said it was the veterans' responsibility to keep it clean.

Additional notes: The Salvation Army leases one of the buildings, while some others are vacant. Surgery, orthopedic and women's health care all share one building.

Louisville VA Medical Center
Louisville, Ky.
Nov. 5, 2002

Demand and Delay: Approximately 280,000 veterans are treated as outpatients, more than 3,000 veterans wait longer than 180 days for initial primary-care visits. Women have to go to a separate clinic; the hospital treats women on an emergency basis only.

Funding: Budget was $131 million. Third-party reimbursements were $6 million last year. This year $11 million was collected. $21 million budget for prescription drugs, $15 million of it was mail-order.

Affiliations/partnerships: University of Louisville for doctors and Ivy League Medical School for nurses.

DoD partnerships: Operates TRICARE Clinic and sharing agreement with Fort Knox.

Staff shortage: Has staff members on light duty, due to injury, one RN per 10 patients. Short on eye-technicians, cataract surgery has a four-month wait. More staff is needed to operate the 168 authorized beds.

Emergency room: With one ER doctor, they handle 50 emergency patients per day.

Long-term care/mental health/homeless: No long-term care. State handles it.

Lexington VA Medical Center
Lexington, Ky.
Nov. 6, 2002

Demand and Delay: Inadequate bed space for patient population. A backlog of 1,300 veterans waits 30 days to six months for primary-care appointments. About 15 new patients enroll per day. Some 7,500 veterans apply for eye care at the Cooper facility; 40 patients a day seek eye care. Audiology clinic is hampered by wait times, as is the optometry clinic. Optometry treats 8,000 veterans a year, and 36 veterans are waiting for pacemakers.

Funding: Lexington VAMC has an operating budget of $125 million. Third-party reimbursements are at $900,000 a month.

Affiliations/partnerships: University of Kentucky doctors receive compensation to treat patients at the VAMC even though they fail to actually treat any veterans. Nurse practitioners perform most of the services.

Staff shortage: Extreme nursing shortage. Able to provide care for 80 of the 105 beds. Two RNs and three or four LPNs are on staff to serve 26 patients. Mandatory minimum overtime is eight hours over a two-week time period. Pharmacists are urgently needed. Pay is inadequate compared with private sector. Due to staffing shortages only seven of the 10 ICU operating beds are used. One technician is expected to draw blood for every patient at Leestown.

Emergency room: One ER doctor treats 60 to 70 veterans a day.

Long-term care/mental health/homeless: Limited to 60 beds, with 56 filled on average. At the Leestown facility there are 61 beds for hospice care, long-term care, rehabilitation and homeless veterans. Psychiatric patients are seen on an outpatient basis. Veterans needing

inpatient psychiatric care are admitted to the Cooper Drive facility, and the more severe cases are sent to Tennessee.

Fourth Mission: There is a coordination plan in place with the city of Lexington and the University of Kentucky to respond in the case of a national emergency.

Leestown VA Medical Center
Lexington, Ky.
Nov. 6, 2002

Demand and Delay: Current operating backlog of 1,300 veterans wait 30 days or longer for primary-care appointments. About 15 new patients enroll each day. Staff reports a waiting time closer to five months.

Funding: Total budget is $125 million. Collected 3 percent more than targeted in third-party reimbursements. Went from $300,000 per month to $900,000 per month in third-party collections.

Affiliations/partnerships: They have an affiliation with the University of Kentucky.

Staff shortage: Due to the nursing shortage they must use agency nurses to augment salaried nurses. Difficulty recruiting and retaining pharmacists. Shortage of specialty doctors, especially optometrists. Also short on lab technicians.

Emergency room: Have only one emergency room doctor to treat 65 to 70 veterans a day.

Long-term care/mental health/homeless: Formerly equipped to treat 1,200 long-term care patients; now operating 56 out of 60 authorized long-term care beds. Leestown facility operates 61 beds for long-term care, hospice, rehabilitation and homeless patients. Psychiatric care is provided on an outpatient basis. Cooper operates 19 beds for psychiatric treatment.

St. Louis VA Medical Center
St. Louis, Mo.
Nov. 12, 2002

Demand and Delay: Staff stated that no patient waits longer than 30 days for an appointment.

Funding: The budget is $180 million. Third-party reimbursement target for FY 2001 was $6 million. $7.5 million was collected. Third-party reimbursements for FY 2002 was $10 million. $11 million was collected.

Affiliations/partnerships: They have affiliations with St Louis University and Washington University.

DoD Partnerships: A sharing agreement with DoD for joint laundry services, mental-health care and spinal cord injury care.

Staff shortage: Staffing has improved recently. Some employees must work overtime to meet demand. The St. Louis VAMC would experience considerable difficulty if employees who are also members of the National Guard or Reserve are called to active duty.

Emergency room: They operate an Ambulatory Care Unit. The ER treats 50 to 70 veterans each day.

Long-term care/mental health/homeless: They have 71 nursing home beds but only operate 65 of those beds due to staffing shortages.

Harry S. Truman Memorial Veterans Hospital
Columbia, Mo.
Nov. 14, 2002

Demand and Delay: 27,000 patients. Number of beds has decreased from 210 to 117 total beds, 77 acute. The fifth floor of the building is empty with plans to remodel and add beds. Veterans travel from as far away as Joplin, 255 miles one way, for treatment because there is no closer VA facility that treats diabetes. The need for more beds in psychiatric and long-term care is obvious. There are 1,000 veterans waiting at least six months to see a primary-care doctor. Waiting list over 120 veterans for three levels of physical-therapy care.

Funding: Operates on a $90-million budget. Last year collected $7.4 million in third-party reimbursements, $1 million over target. Facility brings in extra money by cooking for Meals on Wheels program.

Affiliations/partnerships: Good working relationship with the University of Missouri.

Staff shortage: Short of staff. If National Guard/Reservists were activated, staff of doctors and nurses would fall by 36. Many employees have 20 or more years.

Emergency room: One doctor, one nurse, they see between 25 and 45 patients a day

Long-term care/mental health/homeless: Four hospice beds and room for families to stay. Sixteen beds for substance-abuse care. All 12 psychiatric beds are full, and the need for more is constant. All 41 long-term care beds are full.

Fourth Mission: Serves as DoD backup in case of emergency.

VA Southern Nevada Health Care System
Las Vegas Ambulatory Care Center
Las Vegas, Nev.
Nov. 15, 2002

Demand and Delay: There are 120,000 veterans in the Las Vegas area and 35,221 use VA. Veterans seeking dental care must wait six months.

Funding: The budget is $110 million. Third-party reimbursement goal for FY 2002 was $6.5 million. Third-party reimbursement goal for FY 2003 is $7.2 million.

DoD sharing: They have a sharing agreement with Nellis Air Force Base.

Staff shortage: They are in need of specialty-care doctors.

Additional note: The real problem in Las Vegas is the condition of the facility. The facility was built in 1996 and is virtually unusable. The cost for VA to move out of this building will be $19 million and the cost to lease the new sites would be $4 million.

VA Eastern Kansas Health Care System
Colmery-O'Neil VA Medical Center
Topeka, Kan.
Nov. 27, 2002

Demand and Delay: Some 300,000 outpatients and 6,000 inpatients are seen here. The primary-care wait is 50 to 60 days, not including the waiting time to have your name placed in the computer.

Funding: The operating budget is $129 million. Third-party reimbursements are $10 million. They exceeded their goal and new target is $1 million more than last year. Budget has been straight-lined for past two years.

DoD sharing: They have a contract with DoD for $1 million. They contract with TRICARE.

Staff shortage: Shortages in physicians, dermatologists and audiologists. They are also short on LPNs. One-third of their clinical nurses are National Guard or Reserve. Also staff shortages exist in the ICU where there is one bed filled, but they have 10 beds. They use overtime and contract agencies to fill vacancies.

Long-term care/mental health/homeless: There are 79 beds with 36 filled in the regular nursing home care. There is one psychiatric ward.

VA Central Iowa Health Care System
Knoxville, Iowa
Nov. 29, 2002

Demand and Delay: Some 30,000 veterans are treated each year. Conflicting information on waiting times. Average is anywhere from 60 days to six months for an appointment. Patients needing major surgery are transferred to Iowa City, 100 miles away.

Funding: The FY 2002 budget is $110 million, with third-party reimbursements accounting for $6 million.

Affiliations/partnerships: They have no affiliation, but they do support and are involved with a non-profit group to train physicians at the VAMC.

Staff shortage: Nurses work 40 hours of overtime per month. One RN is responsible for two wards on the weekends and at night. They are short seven nurses in the long-term care ward.

Long-term care/mental health/homeless: Knoxville runs a day-care program for psychiatric patients and cares for 50 to 60 veterans a day. Inadequate staffing and limited hours are two main concerns of the program's continued survival. Patients with dementia and Alzheimer's disease reside in a locked ward much like the mental wards of the 1950s. Twenty-six of the 29 beds are occupied.

Butler VA Medical Center
Butler, Pa.
Dec. 27, 2002

Demand and Delay: Butler has a backlog of 485 veterans awaiting care. It takes seven to 14 days before a new veteran's name is put into the computer. Once a veteran is placed in

the computer the hospital starts recording the wait time. The average wait time after a veteran is in the computer is 51 days. The four CBOCs are filled.

Funding: Budget is between $45 million and $47 million. They collected $3 million this year in MCCF and HSIF. They have collected $1.1 million since October of this year. They receive an additional $100,000 annually in revenue received through rental space.

Affiliations/partnerships: They have one grant program with Catholic Charities through their homeless program.

Staff shortage: They have experienced difficulty recruiting and retaining LPNs and nursing assistants.

Long-term care/mental health/homeless: They operate 86 long-term care beds, down from 106 beds before the Millennium Health Care Bill. They are currently treating 15 to 20 Alzheimer's patients and have a joint initiative homeless program known as the Shawn Place that provides transitional housing. They treat 2,200 psychiatric-care patients each year.

Pittsburgh Healthcare System
Highland Drive Division
Pittsburgh, Pa.
Dec. 27, 2002

Demand and Delay: There are approximately 1,800 veterans awaiting initial primary-care appointments. One-hundred new veterans apply each day. They treat 25,000 veterans at their four CBOCs. The Highland Drive facility provides care for 150 to 200 veterans.

Funding: The FY 2002 budget was $250 million. Third-party reimbursements totalled $12 million in FY 2002. The target for FY 2003 is $14 million.

Affiliations/partnerships: They have an agreement with the University of Pittsburgh.

DoD sharing: They have agreements with DoD to treat Reserve personnel and TRICARE beneficiaries. They also provide dental care to active-duty personnel.

Staff shortage: The Pittsburgh VAMC is offering $750 to anyone who refers a nurse to them who is hired. Approximately 100 employees are members of the National Guard or Reserves.

Long-term care/mental health/homeless: They have 120 long-term care beds and six full rehabilitation beds. They have 50 dementia-care beds. Psychiatric-care beds have been reduced in the last two years. Currently they are remodeling to create a state-of-the-art psychiatric-care facility. The patients were moved from the psychiatric-care wards but no construction for the new facility has begun.

Fourth Mission: University Drive Division has been involved in homeland security planning with the city and county.

VA Salt Lake City Health Care System
Salt Lake City, Utah
Jan. 6, 2003

Demand and Delay: The system treats approximately 300,000 veterans per year, 28,000 of

whom are unique patients. The backlog of 520 veterans wait up to three months before seeing a primary-care doctor. Veterans already in the system usually receive care in less than 30 days.

Affiliations/partnerships: They have an affiliation with the University of Utah Hospital. DoD sharing: They have a sharing agreement with Hill Air Force Base that must be renegotiated with each new base commander.

Staff shortage: They are short on nurses, pharmacists and doctors. They have 70 employees in the National Guard or Reserve.

Long-term care/mental health/homeless: They have 16 beds designated for the care and treatment of veterans with alcohol or drug-abuse problems. They have no long-term care beds. They maintain 15 residential beds for homeless veterans and have a joint program with the county to maintain 60 beds. They have a State Veterans Home on campus. From among 80 beds, 20 are designated for Alzheimer's or dementia patients.

Fourth Mission: They serve as a primary-care site for any biological or chemical attack and as a VA training site for decontamination.

Portland VA Medical Center
Portland, Ore.
Jan. 7, 2003

Demand and Delay: In August 2002, Portland's waiting list numbered 10,000, and so VA contracted out care for 4,500 veterans. There are four CBOCs and veterans wait 60 days to a year to access. Salem Clinic is full. They have had to lay off some housekeeping employees in order to maintain current staffing levels for medical-care providers.

Funding: Budget is $200 million. Third-party reimbursements for FY 2002 were $8.5 million.

DoD sharing: There is a DoD agreement.

Staff shortage: Shortages in physicians, nurses, pharmacists, specialty-care staff and radiological technicians. Between 100 and 120 medical staff members are currently in the National Guard or Reserves.

Emergency room: Operates at full staff and sees about 80 to 100 veterans a day. They maintain a divert emergency care policy. Any veteran who is transported in an ambulance must first go to a public hospital to be treated and then they may be transferred back to VA.

Long-term care/mental health/homeless: Nursing-home care services could be expanded. Portland provides no real care for dementia or Alzheimer's patients.

Fourth Mission: Portland is a primary-care hospital for any bio or chemical warfare treatment.

Boise VA Medical Center
Boise, Idaho
Jan. 9, 2003

Demand and Delay: They treat approximately 15,000 veterans each year.

Funding: They have a budget of $60 million. Third-party reimbursements for FY 2002 were $5.8 million. Third-party reimbursement target for FY 2003 is $7 million.

Affiliations/partnerships: They have an affiliation with the University of Washington.

DoD Partnerships: They have a sharing agreement with Mountain Home Air Force Base. However, this agreement must be renegotiated with every new base commander.

Staff shortage: They need nurses, medical technicians and doctors. They hire retired nurses to ease the shortage of nurses. They have had difficulty hiring and retaining pharmacists. Approximately 20 staff members are in the National Guard or Reserves.

Emergency room: They treat an average of 20 veterans each day in the ER.

Long-term care/mental health/homeless: They transfer any Alzheimer's or dementia patients to the State Veterans Home. Nine of 32 nursing beds are designated for treatment of alcohol and drug abuse.

Richard L. Roudebush VA Medical Center
Indianapolis, Ind.
Jan. 13, 2003

Demand and Delay: They receive approximately 350,000 visits each year. The average wait time is six to eight months for a primary-care appointment. The two CBOCs – in Terre Haute and Bloomington – treat 6,100 and 4,000 veterans respectively and are operating at capacity.

Funding: The budget last year was $167 million. This year the budget is $170 million. They experienced a $7.8 million deficit. They collected $15 million in third-party reimbursements last year with a target of $13 million. The third-party reimbursement target this year is $17 million.

Affiliations/partnerships: They have an affiliation with Indiana University and other medical facilities.

DoD sharing: This VAMC is a backup for active-duty primary care in times of national emergency. They operate a TRICARE Clinic.

Staff shortage: Recruiting and retaining nurses is difficult.

Emergency room: Operates a divert policy in some cases.

Long-term care/mental health/homeless: They have 16 beds set aside for hospice care. Acute beds and extended-care beds are full. Domiciliary beds are operating at 85-percent capacity.

Dayton VA Medical Center
Dayton, Ohio
Jan. 17, 2003

Demand and Delay: The medical center has a backlog of 500 patients while the CBOCs average a backlog of 50 patients. Veterans wait a minimum of two months for an appointment. Two of the four CBOCs are full. The CBOCs treat an average of 4,000 to 6,000 veterans each year.

Affiliations/partnerships: They have agreements with several nursing schools and Rice State University.

Staff shortage: The Eye Care Clinic employees work overtime to meet patient demand. VAMC would experience strain if the 48 employees who are in the Guard and Reserve were activated. They have adjusted pay scales to improve recruitment of nurses, doctors and pharmacists. They have some difficulty recruiting technicians and LPNs

Emergency room: Treats about 50 to 70 patients per day.

Long-term care/mental health/homeless: They have 265 nursing home beds with 45 assigned to Alzheimer's patients. They operate 36 domiciliary beds and a lockdown unit with 18 to 25 psychiatric-care beds. They have adult day care, home-base care, respite care and a 28-step substance-abuse program

Fourth Mission: They have a sharing agreement with Wright Patterson Air Force Base.

Fargo VA Medical/Regional Office Center
Fargo, N.D.
Jan. 23, 2003

Demand and Delay: They treat approximately 23,700 veterans and expect the older veteran population to increase 18 percent by 2012. They have reported a space shortage of 6 percent, and all four CBOCs are operating at capacity. Bismarck has a new clinic that can treat 5,000 veterans. They have a small backlog and enroll 250 new veterans per month. The current wait time for an appointment is one month. Wait time is longer for specialty care. The wait for eye care is one year.

Funding: Their budget is $70 million. Third-party reimbursement target for FY 2002 was $7.9 million. They actually collected $10.1 million. They are currently operating with a $4.8 million deficit.

Affiliations/partnerships: They have an affiliation with the University of North Dakota and with RN, LPN and NA nursing schools. Dental and pharmacy students also are included.

DoD sharing: Fargo has a sharing agreement with Minot Air Force Base. Fargo serves as a backup to Minot for emergency care for the military.

Staff shortage: They have 42 staff members in the National Guard or Reserve. An activation of troops would have a major impact on supplying quality health care.

Emergency room: They do not have an emergency room.

Long-term care/mental health/homeless: They have 50 long-term care beds but no hospice care. Funding for the homeless program was decreased from $172,000 to $30,000. They have treated 2,000 homeless veterans since 1993, including 295 new homeless veterans last year and 37 in December 2002 alone.

Minneapolis VA Medical Center
Minneapolis, Minn.
Jan. 28, 2003

Demand and Delay: They are operating with a backlog of 11,000 veterans waiting for primary-care appointments. They treat 35,000 to 64,000 veterans each year. The average wait

time for specialty care is 20 days. The wait time for eye care is 80 days. They treat 550 new veterans each month. They operate five CBOCs that treat approximately 10,000 total veterans.

Funding: The current budget is $285 million. Third-party reimbursement target last year was $15.5 million. They collected $18 million in third party reimbursements last year. The target this year is $23 million.

Staff shortage: They operate only 80 percent of their authorized beds due to staffing shortages. Nurses work overtime and they contract agency nurses to meet patient demand. They struggle to keep staff in ICU and step-down wards. They currently employ 800 full-time employees. They need neurosurgical doctors. They also are in need of an additional pharmacist. They recently hired a radiologist after a three-year search and had to adjust the starting salary to make the position more attractive.

Emergency room: The ER treats approximately 80 veterans per day. They divert all ambulances en route to the Minneapolis VAMC.

Long-term care/mental health/homeless: The average stay in the psychiatric unit is approximately 30 days. They treat approximately 10,000 patients per year. The psychiatric unit operates a program for women veterans. Some of the contracts for psychiatric treatment are as short as 14 days. They have a contract with a local organization that provides care to homeless patients.

Augusta VA Medical Center
Augusta, Ga.
Jan. 31, 2003

Demand and Delay: The VAMC is divided into two hospitals – uptown (285 beds) and downtown (155 beds). Downtown facility has about 30,000 unique veteran patients, and approximately 500 a month are signing up. Total veteran population served by the facilities exceeds 90,000. No CBOC. No backlog. They claim they can see a veteran in two hours.

Funding: Budget is $159 million. They were asked to collect $7.3 million and collected $8 million. New target is $12.1 million.

Affiliations/partnerships: The Army hospital does cardiac surgery for VA, and VA does neurosurgery for the Army. Agreement with medical schools for doctors, nurses and pharmacists.

Staff shortage: Doctor and nurse shortages are serious. When long-term nurses are short, they put beds out of service. Retired nurses are brought back, part time. The hospital has about 695 full-time equivalents.

Emergency room: Ambulances are diverted. Some 60 to 70 vets a day are treated in the ER.

Long-term care/mental health/homeless: Sixty-bed domiciliary at VAMC. The American Legion provides $10,000 annual grant for Alzheimer's/dementia research. Homeless program has 12 beds, the product of a consolidation with the domiciliary program. Average length of stay is 12 to 13 days. The homeless program is a 30-day to 90-day program. Mental-health patients are treated at the uptown facility. They treat PTSD and have 68 beds for a lock-down unit. Nine females in the domiciliary. The 90 beds they had in 1990 for chronically mentally ill patients has been reduced to 15 due to budget. Hospice and palliative care is contracted out.

Fourth Mission: Backup for DoD hospital for biological chemical warfare. Three employees activated and 49 more possible.

Southern Arizona VA Healthcare System
Tucson, Ariz.
Feb. 3, 2003

Demand and Delay: They treat 41,000 unique veterans and 400,000 cases per year. They have a backlog of 90 veterans waiting 90 to 120 days for an appointment. Approximately 20 to 30 new veterans enroll each day. They operate five CBOCs and each is reaching capacity.

Funding: The FY 2002 budget was $150 million. The third party reimbursement target was $6 million. They collected $6.2 million. The third party reimbursement target for FY 2003 is $10 million.

Affiliations/partnerships: They have an affiliation with the University of Arizona College of Medicine.

DoD sharing: They have a sharing agreement with DoD and must renegotiate that contract with each new Commander.

Staff shortage: They are in desperate need of nurses, especially ICU nurses. The turnover rate for nurses is 8 percent. They have raised pharmacist salaries 16 percent in the last two years to improve recruitment. They have approximately 50 employees in the National Guard or Reserve.

Emergency room: They operate a divert policy when needed.

Long-term care/mental health/homeless: They operate 84 long-term care beds and are currently at capacity. The mental health clinic treats approximately 5,000 veterans each year. They have 26 beds assigned and eight of those beds are in the lockdown ward. They have 14 beds for Alzheimer's patients and 18 beds for hospice care.

Fourth Mission: They are involved in homeland security planning for the local community.

Northern Arizona VA Healthcare System
Prescott, Ariz.
Feb. 4, 2003

Demand and Delay: They treat approximately 18,400 veterans. They have had an increase of 76 percent of patients treated. In 1997 they treated 9,733 and in 2002 they treated 18,400 patients.

Funding: The budget last year was $57 million. This year the budget is $60 million. They collected $3.6 million last year. Their third-party reimbursement target this year is $5 million. They are currently operating at a $1.5 million deficit.

Affiliations/partnerships: They have an agreement with Midwestern University and other medical schools. They jointly purchased an MRI machine with Midwestern.

DoD sharing: A sharing agreement at Camp Navajo.

Staff shortage: Some staff work overtime to meet requirements.

Emergency room: Operates a divert policy in some cases.

Long-term care/mental health/homeless: 16 beds are set aside for hospice care. Acute beds and extended-care beds are full. Domiciliary beds are operating at 85-percent capacity.

Carl T. Hayden VA Medical Center
Phoenix, Ariz.
Feb. 5, 2003

Demand and Delay: They have no backlog according to the facility director. They do however, have approximately 1,200 new veterans enrolling per month. They operate four CBOCs. One is at capacity. Each CBOC treats approximately 3,000 veterans.

Funding: Their budget for FY 2003 is $142 million. The FY 2002 third-party reimbursement target was $9 million. They collected $10.2 million. The FY 2003 third-party reimbursement target is $13 million.

Affiliations/partnerships: They have an affiliation with the University of Arizona and Indian Health Services.

DoD sharing: They have a cooperative agreement with Luke Air Force Base for one of the CBOCs, also a nurses' teaching agreement with the Reserve Unit.

Staff shortage: They are short on nurses and concerned that mobilization of employees who are members of the National Guard or Reserve would prove detrimental to their ability to meet patient demand. They have 104 authorized beds but can only operate 92 due to staffing shortages.

Emergency room: The ER does not provide life-support services. They treat 55 to 60 veterans per day. The ER is open 24 hours and is fully staffed.

Long-term care/mental health/homeless: They have no Alzheimer's or dementia secured area. They have one home for two to three homeless veterans. They work with the community on homeless programs.

Louis A. Johnson VA Medical Center
Clarksburg, W. Va.
Feb. 7, 2003

Demand and Delay: 71 beds, about 85-percent occupancy. Served 17,926 unique patients in 2002, an increase of 5 percent, including 2,300 patients from outside their market area. Total enrollees equal 24,842, and about 200 new patients a month enroll. No waiting list. New enrollees wait 21 days for primary care.

Funding: Budget is $65.2 million. Third-party reimbursement collection target was $4 million; they collected $4.8 million; target raised to $5.9 million. The VISN contracts out third-party collections.

Affiliations/partnerships: Agreements with medical schools.

Staff shortage: No shortage of nurses. They do work some overtime. Radiologists are contracted. There are 23 on medical staff who could be called to active duty. Had to adjust pay

scale to keep pharmacists.

Emergency room: Open 24/7, but staff is limited.

Long-term care/mental health/homeless: Adult day care serves 4,637 patients and VAMC conducts 78,733 home-care visits a year. Seven psychiatric beds. No Alzheimer's/dementia beds.

Fourth Mission: Beds are available for biochemical warfare casualties, decontamination capabilities.

VA Ann Arbor Health Care System
Ann Arbor, Mich.
Feb. 13, 2003

Demand and Delay: Despite evening and weekend primary-care clinics to catch up, the backlog still stands at 613 awaiting appointments 60 days or longer. Three CBOCs and more than 300 new veteran patients a month.

Funding: Budget is $124 million. Third-party reimbursement last year was $7.4 million; they only collected $6.4 million; this year's target is $11 million. Projecting a $7 million deficit and the VAMC has had to use capital-investment funds to cover costs.

Affiliations/partnerships: Physicians are nearly all members of the University of Michigan medical-school faculty. Large research program. Some are contracted out, mainly specialists. School of nursing offers nurses on a rotational basis. Through agreement with DoD, provides examinations for ROTC and Reserves, looking into providing TRICARE.

Staff shortage: Nurses work overtime. Salary structure built to stay competitive with Detroit VAMC. Salary structure adjustments necessary to maintain full pharmacy staffing. Audiology is forced to work overtime to keep backlog under 30 days.

Emergency room: 24/7, mostly walk-ins, about 25 a day, 60 a day for urgent care.

Long-term care/mental health/homeless: No beds set aside strictly for Alzheimer's/dementia or hospice care. Eighteen beds designated for acute psychiatric care. Homeless care is contracted out. No domiciliary beds.

Fourth Mission: Ready for distribution of smallpox vaccine.

Central Arkansas Veterans Health Care System
John L. McLellan Memorial Veterans Hospital
Little Rock, Ark.
Feb. 18, 2003

Demand and Delay: No serious backlog. Veterans can be seen in about 20 days. About 400 new veterans enrolling a month. About 52,000 unique patients a month. Workload has increased 40 percent while the work force has increased by 3 percent. Backlog for audiology is nine months. They operate one MRI and could use another, as more than 1,000 veterans are waiting for imaging.

Funding: Budget is $280 million. Third-party reimbursement target last year was $13 million; they collected $14 million; new target is $16.4 million. They have come close to using capital-investment money.

Affiliations/partnerships: Schools of nursing in the area. University of Arkansas medical school/great research program. Limited DoD agreement. VA provides physicals. Limited agreement with air base.

Staff shortage: Staffing is a problem. Nurses are in short supply. Overtime must be used, contract agency nursing, too. Also planning to bring in retired nurses part time. Short on neurosurgeons. They have a need for more flexible pay for doctors and are forced to contract out physician services because they cannot offer competitive pay. VAMC does not know how many on staff are National Guard or Reserves, although some have been activated.

Emergency room: 24/7 with diversion program, about 1,600 patients a month.

Fourth Mission: Involved in Homeland Security and serves as a primary hospital in case of military evacuation. They have a special team to train for bio-chemical attack and have already begun distributing smallpox vaccinations.

G.V. "Sonny" Montgomery VA Medical Center
Jackson, Miss.
Feb. 19, 2003

Demand and Delay: Six CBOCs, all on contract, each of which sees 1,000 veterans a day. The hospital has 40,000 enrolled veterans, 36,000 in primary care. No backlog for primary care reported, but the wait time for eye care is six months or more. Saturday clinics are offered to reduce cardiological and orthopedic backlogs. In addition to all the Priority Group 8 veterans who are now being turned away, they are still enrolling 20 to 25 veterans a day for primary care. Maintain 90 percent occupancy in acute beds and 95 percent in nursing home.

Funding: Budget is $165 million. The target last year for third-party reimbursements was $10 million; they collected $10.5 million; new target is $14 million.

Affiliations/partnerships: National Guard and ROTC arrangements, dental and TRICARE.

Staff shortage: Paying $350,000 for contract orthopedic doctor who would cost $185,000 on salary. Using a float pool of nurses and contract nurses. 10 employees from the National Guard/Reserves who are activated and potential for 60 more. If all are activated, surgeries would have to be canceled and patients would have to be discharged. They could use 20 more nurses but don't have the budget for it. Pay scale restructuring necessary to keep pharmacists.

Emergency room: Some 70 patients a day, 24/7, no divert program. The ER has a research and education program which the director says helps attract doctors.

Long-term care/mental health/homeless: Alzheimer's patients are mixed with psychiatric patients. An addition is needed to handle demand. They now have four long-term patients in a room and no private shower or private bathroom facilities in the rooms. The CARES process has determined the need to open a mental-health clinic.

Central Alabama Veterans Health Care System
Montgomery, Ala.
Feb. 21, 2003

Demand and Delay: No backlog. Veterans can get appointments the next day. Workload has

increased 6 percent this year, 9 percent the previous year. 60 new veterans a week sign up for primary care. More patient growth is predicted, and staff is working full time on CARES, needing more services.

Funding: Budget is $130 million. Third-party target last year was $5.7 million, collected $6 million, new target is $7.9 million. They have hired an outside contractor to collect this money at 9 percent of the take, which raises the question: what is to protect families from collection agencies when insurance companies don't pay the full rate?

Affiliations/partnerships: DoD sharing with three Army forts. They do separation physicals but have trouble with command changes. They treat some TRICARE but have cut it off out of fear their staff won't handle it and the regular primary-care waiting list will pass 30 days. Affiliations exist with Morehouse College for Doctors and with some local nursing schools.

Staff shortage: Some difficulty staffing nurses. Contract out cardiology. Staff works overtime, but it is not mandatory. The hospital has 10 employees already activated and a possible 65 or 70, half of them caregivers, who could be called up. Special pay for pharmacists, active in the Virtual Pharmacist program. In the ICU, nurses said they were short-handed.

Emergency room: They have an ER at both campuses – Montgomery and Tuskegee – both operating 24/7 without a divert program.

Long-term care/mental health/homeless: Of the 160 beds in the VAMC, 60 are designated for dementia. Hospice is treated in the community, but they do have a hoptel.

Fourth Mission: Secondary military hospital, planning inoculations, involved in the community for disaster or terrorist attack.

Additional note: The director did not tour the facility with the commander. For the first time in all these visits, a veteran told the commander the quality of care was poor.

Birmingham VA Medical Center
Birmingham, Ala.
Feb. 22, 2003

Demand and Delay: In the past five years, the number of unique patients has grown from 20,000 to 45,000. The VAMC has 52 exam rooms and needs 20 more. They operate six CBOCs, all VA-staffed, all of which have been expanded three different times to meet increased demand. The CARES plan calls for five more CBOCs. The VAMC has about 150-200 veterans waiting 30 days or longer for primary care. The CBOCs are worse, with 300 each waiting 30 days or longer. If asked to perform as primary-care hospital for troops, veterans would have to be discharged due to lack of staff and space. The VAMC is short approximately 200,000 square feet to provide adequate care.

Funding: Total budget of $128 million. Target for third-party reimbursements was $12 million; they collected $13 million; new target is $13.7 million. Capital-investment funds have not been used in day-to-day operations, but those funds have been reduced.

Affiliations/partnerships: University of Alabama-Birmingham affiliations bring in 104 interns who rotate every quarter. DoD agreement to do physicals for Reserves and at military discharge. Primary-care hospital for active duty if needed.

Staff shortage: Shortages in doctors, nurses and technicians, especially short on specialty nurses. On staff are 140 employees in the National Guard and Reserve. Pharmacist pay scales have had to be adjusted to $85,000 to $90,000 a year in order to compete with

Atlanta, Ga., pharmacies that offer a Mercedes-Benz as a signing bonus to pharmacists.

Emergency room: 24/7, sometimes 60-70 patients a day, six or seven of whom will be admitted to the hospital.

Long-term care/mental health/homeless: No long-term care; it's contracted out, as is Alzheimer's/dementia. Psychiatric cases are all outpatient. Director said 40-60 percent of patients have mental-health problems. About 45,000 visits a year and about 7,000 unique patients. No hoptel or facilities for families to stay while a veteran is in ICU.

Fourth Mission: Involved in Homeland Security.

Additional note: Director Y.C. Parris was a breath of fresh air, the first director to accompany me, candidly, as we toured through the rooms, meeting veterans, on Saturday. He learned from one veteran that he could not get into the Huntsville CBOC for the past 18 months and he came to Birmingham on his own, where he could get looked at. They brought the kidney under control and discovered he needed open-heart surgery. This was the first director who went with the commander and directly asked how patients were feeling.

Ralph H. Johnson VA Medical Center
Charleston, S.C.
Feb. 24, 2003

Demand and Delay: Approximately 600-700 wait six months to a year for appointments. About 3,000 veterans sign up every year and the total patient load is 35,000. Three CBOCs in the VAMC, all VA-staffed. A 100-percent increase in square footage is the CARES recommendation.

Funding: Annual budget of $150 million. Third-party reimbursement target was $9.1 million; they collected $9.4 million; target increased to $12.4 million. Collection agency hired at 10.5 percent.

Affiliations/partnerships: A movement is under way for the VAMC to merge with the Medical School of South Carolina. Strong research program.

Staff shortage: Nursing shortages have forced this VAMC to close beds. Shortages of anesthesiologists, chief of surgery and chief of primary care. Doctors are contracted in. If not for the university affiliation, this VAMC would have great difficulty operating. Pharmacist pay scales have had to be modified. Eight employees at this time activated, could lose 28 more to military service.

Emergency room: Operates only from 7 a.m. until 10 p.m. During off hours, patients are diverted to other facilities.

Long-term care/mental health/homeless: With 28 beds available, only 26 can be kept full because of nursing-staff shortage. Two Alzheimer's beds and 16 psychiatric beds. Alzheimer's/dementia patients are placed among general hospital population.

Fourth Mission: Secondary military hospital, limited involvement in homeland security and natural disaster preparedness.

William Jennings Bryan Dorn VA Medical Center
Columbia, S.C.
Feb. 26, 2003

Demand and Delay: 47,000 veterans a year. In the past six years, 63-percent increase in inpatients. They have six CBOCs and plans for a seventh. Backlog is about 875 to 900 who are waiting 30 days or more. Conducting 600-800 C&P exams per month.

Funding: Budget is $146.4 million. Target for third-party reimbursements was $7 million; they collected $10 million; new target is $13 million.

Affiliations/partnerships: South Carolina School of Medicine since 1977, campus is on the VAMC property. On any given day, 50 or more residents/students are working at this VA. Affiliation is vital to both the school and the VA. $11 million research grant for colorectal cancer. School's budget of $28.5 million is being cut to $23 million.

DoD partnerships: Several agreements – Moncrief Army Hospital, Shaw AFB, TRICARE, U.S. Naval Reserve and Army Reserves. MRI-sharing and blood-sharing program with DoD, which saves approximately $250,000 a year.

Staff shortage: Nursing shortages drive incentive program where employees who recruit a nurse receive $500; if the nurse signs, it's $1,000. A new nurse receives a $5,000 signing bonus. Short on radiologists and other technicians. To keep pharmacists, they have had to modify salary structure. Because of shortage of critical nurses, ICU has been consolidated. On staff are 143 National Guardsmen and Reserves – 29 nurses and three doctors. A major call-up would strain staff.

Emergency room: Operates from 8 a.m. to 8 p.m. Sees some 75-80 patients a day. Divert program used once in a while.

Long-term care/mental health/homeless: VAMC sees 8,200 unique mental-health patients a year, comprising 59,000 visits. 10-12 psychiatric beds. No dementia unit. Mental health expansion needed.

Fourth Mission: Air Force hangar is hospital backup in case of troop evacuation. Smallpox vaccination volunteers (135) available; vaccine to be administered by the county health department.

Anchorage VA Healthcare System and Regional Office
Anchorage, Alaska
March 6, 2003

Demand and Delay: Patients who need specialty care are flown to Seattle. Patient load has grown 16 percent over the past five years. Backlog of about 1,000 veterans. All veterans with less than 50 percent service-connected disability are placed on a waiting list because they don't have enough money to care for them. All veterans will be rescreened and re-categorized.

Funding: One-half the budget goes for contract services. Budget is $80 million; last year it was $79 million, which is not really an increase because the director was asked to collect $2.8 million in third-party reimbursements last year; he collected $3.5 million, and so his new target is $5 million. Therefore, he loses half a million in the end.

Affiliations/partnerships: Agreement with Elmendorf AFB.

Staff shortage: Not enough doctors, especially in specialty areas. Recent shortage of nurses, short six ICU nurses in joint venture with Elmendorf AFB.

Emergency room: Sees about six to 10 veterans a day.

Long-term care/mental health/homeless: VAMC has 50 beds for homeless, the rest (about 3,000 total) are vouchered to HUD. Alzheimer's/dementia care is contracted out ... 13 different contracts. No hoptel due to lack of funds.

Iron Mountain VA Medical Center
Iron Mountain, Mich.
March 12, 2003

Demand and Delay: About 150 people are waiting six to eight months for primary-care appointments. Among six CBOCs, four are full. Number of unique patients has increased from 12,407 in 2000 to 15,374 now.

Funding: Budget is $45 million, up from $40 million last year. Target for third-party reimbursements was $4 million; they collected $4.6 million; new target is $5.6 million.

Affiliations/partnerships: No med school, but affiliations with nursing schools.

Staff shortage: Difficulty hiring LPNs and RNs in the ICU. Short on doctors and have had to contract out specialty-doctor care. Two National Guard doctors called up. Three months ago, forced to work overtime due to shortage. Now overtime is on an as-needed basis. Pay scale has had to be changed for pharmacists.

Emergency room: Operates 24/7, sees an average of six veterans a day.

Long-term care/mental health/homeless: 20 hoptel beds, Alzheimer's patients are sent to nursing homes or to Marquette. Home health care is contracted out. They have a mental-health clinic at each CBOC and about 1,300 mental-health patients a year. No numbers on homeless. Hospice care available, no adult day care.

Fourth Mission: One of 75 decontamination sites, volunteers are lined up to deliver smallpox vaccinations.

Wilmington VA Medical and Regional Office Center
Wilmington, Del.
March 13, 2003

Demand and Delay: Director reluctantly admitted backlog of 1,000 in lower Delaware, waiting some six to nine months. In lower New Jersey, some 500 wait six to nine months. The survey response from this VAMC reported there was no backlog at all. Occupancy 98 percent in the nursing home and 80 percent in the hospital.

Funding: Budget is $62 million. Third-party target was $3 million, they collected $3.2 million, now the target is $6 million.

Affiliations: They do physicals for Reserves, in contract with DoD.

Staff shortage: Short one doctor, difficulty keeping pharmacists. Nurses work overtime. If National Guardsmen activated would have to close some beds. Short-staffed security is a strain on the budget.

Emergency room: 24/7 operation. At first, the director said they saw six veterans a day, but then he changed that figure to 70.

Long-term care/mental health/homeless: No area set aside for Alzheimer's/dementia, no hospice care, but do offer palliative care. Mental-health care is contracted out. No beds for homeless. No adult day care.

VA Maryland Health Care System
Baltimore, Md.
March 15, 2003

Demand and Delay: Workload increased from 44,000 veterans to 50,000 veterans in 2002. They operate six CBOCs, one at capacity.

Funding: The FY 2003 budget is $334 million. It was $310 million in FY 2002. The target for third-party reimbursements last year was $7 million. They managed to collect $10 million. Third-party reimbursement target for FY 2003 is $15 million, an increase of more than 100 percent.

Affiliations/partnerships: They have an affiliation with the University of Maryland and other nursing schools.

Staff shortage: They run a 7-percent vacancy rate on nurses. They are short on specialty doctors. The ER uses agency nurses. Personnel must occasionally work overtime.

Emergency room: The ER operates 24/7. They treat an average of 120 veterans per day. They have a short-term divert program.

Long-term care/mental health/homeless: The nursing home facility is 85-percent full. They operate a psychiatric adult-care program at Perry Point and have a homeless program with MCVET that operates 200 beds. They have a 50-bed dementia unit in Loch Raven. They have a lockdown unit with 18 beds for alcohol and drug rehabilitation and six beds for PTSD treatment.

Fourth Mission: This is a primary receiving facility for DoD and part of the local Homeland Security program.

Additional note: They have implemented a 10-percent retention bonus for lab technicians.

Philadelphia VA Medical Center
Philadelphia, Pa.
March 20, 2003

Demand and Delay: 5,600 veterans waiting six months or longer. 7,500 new veterans have signed up in the past six months.

Funding: Budget is $201 million. Third-party target was $9.6 million; they collected $9.65 million; new target is $12 million. This facility has never had a problem collecting outstanding receivables, but the VISN has mandated that they use outside collection agency.

Affiliations: University of Pennsylvania, ER is contracted to the university 7 p.m. to 7 a.m. Parkinson's Disease research program, also one of four sleep-study programs. They have received $22 million for the research, but the labs are 30 years old.

Staff shortage: They are short on nurses and doctors but aggressively recruit. Maintain five primary-care teams and three specialty-care teams. They want waiver of J1 rule. They are short nurses in the nursing home.

Emergency room: Operates 24/7, seeing about 40 veterans a day, 24 percent admitted.

Long-term care/mental health/homeless: 240-bed nursing home that maintains 96-percent occupancy, no set-aside area for Alzheimer/dementia. Average age is 72 with some form of dementia. About 9,000 unique mental-health patients and about 90,000 visits a year. They have a hoptel but no hospice.

Fourth Mission: Primary care for the DoD. Has Homeland Security program.

VA Nebraska Western Iowa Health Care System
Omaha, Neb.
March 24, 2003

Demand and Delay: Group of three hospitals and two CBOCs. The Lincoln VA has turned inpatient care over to a local hospital under contract. The Grand Island facility also contracts with a local hospital for primary care, where nursing home care is provided. Backlog of 307 veterans wait seven months or longer for primary-care appointments. Before January, 350 to 450 veterans per month were enrolling. Now it's about 250 a month.

Funding: Budget is $165 million. They were asked to collect $14 million in third-party reimbursements, collected $15 million and received new target of $18.9 million. Collections over 90 days are turned over. Capital-investment funds have been used heavily to meet operational costs. Two-thirds of the funds have been used the past two years and half the funds are expected to be used this year. This means no new equipment.

Affiliations/partnerships: Affiliations with Creighton University Medical School and the University of Nebraska.

Staff shortage: Nursing shortage leads to use of agency nurses and retirees. Nurses work overtime. Also short some doctors. Had to reconstruct pharmacist pay scales to keep them. Still short. Also short technicians, radiologists and LPNs. They have had to pay finder's fees, bonuses and retention allowances. They have 102 members in the National Guard and Reserves, two activated.

Emergency room: ER operates 24/7 with 10-percent admittance.

Long-term care/mental health/homeless: At Grand Island, 76 long-term care beds are available with staff to handle 65. No beds for Alzheimer's/dementia patients. They send some to Knoxville, Iowa, 250 miles away. No psychiatric-care beds. 6,247 unique mental-health patients represent 84,900 visits a year, including 408 psychiatric admissions. No mental-health care in the CBOCs.

Fourth Mission: This is a primary-care center for the military and 103 employees have been vaccinated, to date.

Providence VA Medical Center
Providence, R.I.
April 6, 2003

Demand and Delay: 2,000 veterans wait up to a year to see a primary-care doctor. 300 to 400 new veterans sign up every month. Three CBOCs operate over 100-percent capacity and still taking new veterans.

Funding: $96-million budget, hoping for $103 million. Last year's third-party target was $4 million; they collected $5.5 million and now have a target of $6.2 million. They handed an agency 2,000 patient names, and the agency found that 200 of them had third-party insurance willing to participate. They have had to use capital-investment funds for regular operations in the past six years and now need new equipment. Director said they need stable funding.

Affiliations: Brown University and Rhode Island Hospital.

Staff shortage: Difficulty finding and keeping nurses, doctors, LPNs and techs. Agencies are paid finder's fees to get them. Signing bonuses are paid. J1 visas are used. Pharmacy shortage so they contract with Chicago VAMC to fill prescriptions midnight to 7 a.m.

Emergency room: 24/7, about 40 a day, 20 percent admitted.

Long-term care/mental health/homeless: No long-term care or Alzheimer's beds. They contract with the state veterans home and with VA in Boston. About 5,000 to 6,000 unique mental-health care veterans. They have 15 beds set aside for mental-health patients. One ward of the state veterans home is set aside to care for homeless veterans.

Fourth Mission: Also a primary-care hospital for DoD with beds they can put immediately into service. Also serve state and city for emergency care.

Albany VA Medical Center: Samuel S. Stratton
Albany, N.Y.
April 10, 2003

Demand and Delay: 34,000 veterans a year. 11 CBOCs and two primary-care units. Only one CBOC is full. Three are fully staffed by VA. 85 new veterans a month enroll. Third-party collections are turned over to an agency.

Funding: Budget of $130 million. They did not know their target for third-party reimbursements. Was told that HMOs do not have to pay for VA care, but Blue Cross and Blue Shield do.

Affiliations: Affiliations with four nursing schools but no students yet. Affiliation with Albany Medical College. They get about 70 interns a year.

Staff shortage: Short on doctors, nurses, technicians and pharmacists. No agency nurses, no finder's fees, no recruitment bonuses; instead they are going from three inpatient critical-care wards to two and from two long-term care wards to one. Most doctors are on contract. The cost difference for a retina doctor is $435,000 for contract doctor on half-days compared to $175,000 for a payroll doctor. They have 31 employees who are in the National Guard.

Emergency room: 24/7, about 25-40 a day, 15-20 percent are admitted.

Long-term care/mental health/homeless: No Alzheimer's beds, but they do have a memory-disorder clinic. About 4,000 unique mental-health patients a year.

Fourth Mission: Primary receiving facility for U.S. military. Eight nurses have received smallpox vaccinations.

Additional note: As I walked up to this facility, I noticed that many windows had air conditioners in them. I asked why. I was told that half the facility was air-conditioned, and for years, it has been on the books to air-condition the rest of the facility. Veteran complained that he only saw nurse practitioners and never a doctor.

VA Connecticut Health Care System
West Haven, Conn.
April 14, 2003

Demand and Delay: Signs up 400 new veterans a month. Number of unique patients up from 35,000 in 1998 to 50,000 now. Dollars do not keep up with demand. The facility has four teams: two for primary care, one for elderly care and another for mental health. The facility has 7,200 unique mental-health cases and about 150,000 visits a year.

Funding: They have had to dip into their capital investment fund for day-to-day operations for three years in a row. They have a shortage of nurses, doctors, techs and pharmacists. Third-party reimbursement target was $12 million last year. They collected $13 million. Now the goal is $19.6 million.

Affiliations: Affiliation with Yale and University of Connecticut generates $30 million in research a year. 90 percent of their full-time doctors are affiliated with Yale.

Staff shortage: Active J1 program. Affiliations with several nursing schools. Pay finder's fees and signing bonuses. They share staff with other local hospitals. 35 employees are in the National Guard and can be activated anytime.

Emergency room: 24/7, but no one knew how many patients per day.

Long-term care/mental health/homeless: No separate beds for Alzheimer's or dementia patients. There is a hospice program and a hoptel for families. Active homeless program.

San Juan VA Medical Center
San Juan, Puerto Rico
April 17, 2003

Demand and Delay: 102,000 enrolled and 51,660 unique patients, but no waiting list. About 360 new veterans enroll a month. Four CBOCs and two satellite offices. 348 beds, 93-percent full. 120 nursing-home beds, 100-percent full, with waiting list. Planning now for a new hospital. Congress has already approved a new CBOC.

Funding: Budget last year was $240 million, this year $280 million. Third-party reimbursement target was $8 million; they collected $8.2 million; new target is $16 million. They feel they can collect $11 million. Outsource collections at a rate of 25 percent.

Affiliations: Affiliations with three different schools – 900 trainees and 137 medical residents.

DoD Partnerships: Numerous agreements with DoD.

Staff shortage: Shortages of nurses, technicians and doctors. Medical staff must work overtime. Nurse-to-patient ratio has increased. 234 employees are National Guard or Reserve, 60 activated.

Emergency room: 24/7.

Long-term care/mental health/homeless: 120 nursing-home beds, 100-percent full with waiting list. No separate unit for Alzheimer's/dementia. Hospice but no adult day care, aside from mental-health day care. 10,387 unique mental-health patients

Salisbury W.G. Bill Hefner VA Medical Center
Salisbury, N.C.
April 22, 2003

Demand and Delay: 10,500 veterans on the waiting list and 1,100 new veterans enroll every month; $17 million and 75 new doctors to lead primary-care teams are scheduled to be brought in to help bring down the backlog. Director said he did not know where the $17 million was coming from. Veterans report having to wait a year for an appointment. This hospital represents half of the entire VISN's 22,500 backlog. Priority Group 8 veterans represent 37 percent of those enrolled. No plans to handle new veterans from Iraq.

Funding: Chief of staff reported that 18 percent of the veterans have diabetes and the cost to care for them is about $16 million. The entire budget is $135 million. Third-party reimbursement target last year was $4.8 million; they collected $6.3 million; their new target is $11 million. They have been running a deficit and are using capital-investment funds for health care.

Affiliations: Affiliations with Wake Forest University and 67 others.

Staff shortage: All areas. No bonuses or finder's fees for nurses. Some agency nurses. They work a lot of overtime. Forty employees are National Guard/Reserve.

Emergency room: 24/7, admitting 60-75 patients a day.

Long-term care/mental health/homeless: Outreach program for the homeless, 55 beds. All 203 nursing home/Alzheimer's beds are full, but one wing is closed due to shortage of staff. Could go up 270 beds. About 7,000 unique mental-health veterans per year. 700 unique homeless cases a year.

Manchester VA Medical Center
Manchester, N.H.
April 28, 2003

Demand and Delay: Four CBOCs are full, and yet still allowing new enrollees. Two are VA staff, two are contracted. About 18,000 unique patients a year. Prior to last January's Priority Group 8 cutoff, 500 were enrolling each month. Now about 150 a month. About 128,000 visits per year. The waiting list for primary care has been cut from 1,000 to 760 since March. The average wait is 10-12 months. Some veterans move up in line when American Legion service officers lobby on their behalf. Staff has been reduced from 650 to 500.

Funding: Budget is $60 million. Last year's target was $4 million on third-party reimbursements; collected $4.1 million and received a new target of $5 million. Last year operated on a deficit. This year confident can get within budget. They have had to use capital-

investment money for day-to-day operations. Collection agency gets 10 percent. Facility unaware of agency's ability to collect from families when insurance companies come up short.

Affiliations/partnerships: Dartmouth College (three doctors) and other medical schools (about 40 med students). Also provide physicals for DoD.

Staff shortage: Short on nurses, technicians, pharmacists, doctors and specialists, up until about three months ago. They pay no finder's fees nor retention bonuses and little recruitment bonus. Shortage of radiologists and pharmacists. Audiology is short, too, and appointments are booked through November (seven months). One veteran said he had to wait a year and a half for a hearing test.

Emergency room: 24/7, sees 40-60 patients a day, but since the hospital has no acute-care beds, those veterans are transported to Boston, White River or a nearby hospital. 25 percent need to be admitted.

Long-term care/mental health/homeless: 60 nursing-home beds but at the time of this visit, only 49 filled. No Alzheimer's/dementia or mental health beds. No numbers available on mental-health patients. Director thinks it's 15-20 percent. One CBOC has a mental-health team. No beds for substance-abuse cases.

Additional notes: This facility has no acute-care beds ... acute care shut down for the past four years. At the beginning of the meeting, the director said, "Veterans should be treated by VA staff but not in a VA facility, in a leased facility." Clearly, he favored closing down this VA. The second floor was closed down 16 months ago so it could be remodeled, opening up 60 more nursing-home beds. No work has begun, no contract let, the floor manager blamed Congress and the CARES process. Severe parking problems and no plan to correct them.

Spokane VA Medical Center
Spokane, Wash.
May 12, 2003

Demand and Delay: 3,000 veterans waiting, takes 18 months to see a primary-care doctor. Center sees 19,299 veterans.

Funding: Budget is $70 million. Third-party reimbursement target is $2.8 million, which they collected. New target is $4.3 million.

Affiliations/partnerships: University of Washington and other schools for nurses, technicians, pharmacists and clerical. Five affiliations total.

Staff shortage: They need to hire more doctors, nurses, techs and pharmacists. Had to double police staff and arm them under new security requirement.

Emergency room: VA-staffed during the day, operates 24-7 (contract-staffed at night), divert program.

Long-term care/mental health/homeless: Eight mental-health beds, operates hospice care, 2,800 mental-health patients, 500 POWs and 100 homeless.

Jonathon M. Wainwright Memorial VA Medical Center
Walla Walla, Wash.
May 13, 2003

Demand and Delay: 1,207 veterans waiting up to one year for primary-care doctors, 35 new patients per month and 11,800 veterans seek care per year.

Funding: Budget is $35 million. Third-party reimbursement target is $1.9 million, $2.2 million collected. New target is $3.1 million.

Affiliations/partnerships: Walla Walla Community College and Walla Walla College to provide nurses and social workers.

Staff shortage: Shortage of radiologists, nurses, technicians and certain doctors. Pharmacist pay has been changed three times this year. Had to hire three police officers, still need three more. 10-12 employees in Guard or Reserve, with one activated.

Emergency room: No ER, but walk-in clinic for emergency care that is VA-staffed 24-7.

Long-term care/mental health/homeless: No Alzheimer's unit, but they have lodging for patients. No family lodging. Mental-health patients comprise 22 percent or 2,500

Additional note: During the tour, a female vet told me that she comes from Oregon for treatment because she believes "it's the best."

VA Puget Sound Health Care System
Seattle, Wash.
May 14-15, 2003

Demand and Delay: Of the 455,760 veterans in the market area, these facilities served 54,594 in 2002 and about 1,000 fewer the previous year. Among those, they average nearly one visit a month per veteran. The facility has 315 acute beds, 131 nursing-home beds, 60 domiciliary beds and five transitional homes with 60 beds. Short by 57,912 square feet in research space. In July 2002, the six-month waiting list was 5,000. By March it had been reduced to 1,500. Tele-health program reduces backlog. Expecting a 39-percent increase in patient load by 2012, and specialty care is expected to increase by 123 percent, inpatient care by 35 percent. About 600 new veterans are enrolled each month. Approximately 1,000 compensation and pension examinations per month. Twenty-three out of 26 examiners are non-VA physicians, hired on contract. Waiting period for exams is 25 days or less.

Funding: Budget is $296 million, up from last year's $275.5 million. VA provides $11.9 million for research, and another $417.6 million comes from outside VA. Third-party reimbursements for last year were $13.2 million; target was $11.2 million; new target is $19 million. This VAMC has had to use capital-investment money to cover costs.

Affiliations: Affiliated with the University of Washington medical school.

DoD Partnerships: Sharing arrangement with Madigan Army Hospital. All the land at American Lake is leased from DoD, which leases it from the city and the county. If the Army presence ends, the property reverts back to the city.

Staff shortage: The VAMC has 2,581 employees. Research dollars essential to keeping physicians. They use some J1 visa doctors. Some difficulty recruiting and retaining nurses. They pay finder's fees for nurses, plus retention and signing bonuses. Pharmacists are

paid special rates. Of the 50 employees in the National Guard, 12 are activated. Short staffing has emptied beds in the ICU. Staff shortages are leading to empty beds at the American Lake facility.

Emergency room: ER operates 24/7 at American Lake and has a divert program. Between the two ERs, about 120 veterans are seen a day.

Long-term care/mental health/homeless: Alzheimer's units/nursing-home care needed at American Lake facility. Seismic concerns are serious. Approximately 12,600 unique mental-health patients.

Additional note: Earthquake damage to building is a serious concern. Veterans now on the second floor could not get out in case of an emergency.

Edward Hines Jr. VA Hospital
Hines, Ill.
May 16, 2003

Demand and Delay: 1,000 vets wait more than six months. Long waiting times for specialty care, especially audiology. Veterans seeking care increased by 10,000. 150-200 new vets per week and since January they've had 162 Priority Group 8 veterans apply. Five of the seven CBOCs are full.

Funding: Budget is $147 million. Last year had $13-million deficit and used $700,000 out of the equipment budget. Third-party reimbursements last year were $16.2 million and collected $16.8 million. New target is $22 million.

Affiliations/partnerships: Loyola University.

Staff shortage: Seven vacancies in specialty care. Finder's fees and bonuses paid for spinal-cord specialists. Special pay for pharmacists, contract out for nurse assistants. Fifty employees belong to Guard or Reserve, seven called to active-duty.

Emergency room: 24-7, sees 40-80 per day, has divert program.

Long-term care/mental health/homeless: No beds for Alzheimer's patients. Has hospice-care program, McDonald House and hoptel beds. Treats 5,000 mental-health patients and 25 homeless veterans. Maintains psychiatric beds and leases to Catholic charities for the homeless.

Fourth Mission: Employees have not yet been vaccinated for smallpox. Participated in Top Off disaster drill. Primary-care back-up to Milwaukee VAMC – with Milwaukee being primary back-up to the military.

VA Chicago Health Care System
Chicago, Ill.
May 17, 2003

Demand and Delay: 60 inpatient beds to close, 120,000 visits per year, radiation treatment unavailable, treat mostly poor and indigent. 500 C&P exams. Tertiary care is scheduled to close and move to West Side.

Funding: $210-million budget, third-party reimbursements target was $12.8 million and collected $13.2 million. New target is $14.7 million. 300 faculty physicians provide free

care (University feels this is worth $30 million- $50 million, while VA feels this is worth $100 million.)

Affiliations/partnerships: Affiliated with Northwestern University Medical School, plus schools for nursing and pharmacy.

Staff shortage: Nurses migrating to other hospitals, straining the ICU and critical-care units. Additionally, ER will close from midnight – 7 a.m. because of shortages. 80-90 employees belong to Guard and Reserve, 10 have been called up.

Long-term care/mental health/homeless: Long-term care will go to Hines VAMC.

Fourth Mission: This VA was involved in Top Off (disaster drill).

Additional note: The reasons for closing this VA are suspect and have nothing to do with the care of the veteran.

Mountain Home VA Medical Center
Mountain Home, Tenn.
May 19, 2003

Demand and Delay: They serve 35,000 veterans, comprising only 24 percent of the market. There are 300 to 400 veterans waiting more than 30 days and less than 60 days for a primary-care appointment. They have 20 new veterans applying each day.

Funding: The budget is $136 million. Third-party reimbursements totaled $11.3 million last year. The FY 2003 target is $13.2 million. They are operating at a $7.5-million deficit.

Affiliations/partnerships: They have an affiliation with the University of Tennessee Medical College.

Staff shortage: They are short doctors in urology and neurosurgery. They have difficulty recruiting and retaining technicians and pharmacists. They have 37 employees in the National Guard or Reserve.

Emergency room: The ER operates 24/7 and is contracted out. They treat between 50 and 120 veterans per day. On average 27 veterans are admitted daily. On weekends six to nine veterans are admitted. They are authorized 111 beds but use only 81.

Long-term care/mental health/homeless: They have a 120-bed nursing-home facility. They do have a hospice program and a hoptel for family members. They have a full psychiatric program but no Alzheimer's unit. They have a 120-day drug and alcohol program.

Tennessee Valley Health Care System
Murfreesboro, Tenn.
May 20, 2003

Demand and Delay: They have 142 operating beds with only 123 currently filled. They have 50 veterans waiting less than 30 days for a primary-care appointment. They have denied enrollment of 543 Priority Group 8 veterans since the suspension of enrollment announcement. They average 55 new veterans enrolling each day.

Funding: The budget is $285 million. Third-party reimbursement last year was $17 million. They collected $19 million. The new target is $21 million.

Affiliations/partnerships: They have an affiliation with Vanderbilt University.

DoD Partnerships: Sharing agreements with Fort Campbell and Fort Knox.

Staff shortage: They have a shortage of specialty-care doctors. They are short LPNs and pharmacists. They have 72 employees in the National Guard or Reserve.

Emergency room: ER operates 24 hours a day. Nashville ER averages 50 veterans each day, and the Murfreesboro ER averages 55 patients.

Long-term care/mental health/homeless: They are planning an outside therapy area for Alzheimer's patients. They have 298 operating beds and 165 nursing home beds. They have a hospice program. They have a hoptel for families of patients.

New Mexico VA Health Care System
Albuquerque, N.M.
May 28, 2003

Demand and Delay: There are 40,000 veterans enrolled in New Mexico. They operate six CBOCs. Backlog is approximately 659 veterans awaiting primary-care appointments.

Funding: The budget is $198 million. Third-party reimbursement target last year was $8 million. They collected $7.5 million. The new target for third-party reimbursements is $10.5 million.

Affiliations/partnerships: They have an affiliation with the University of New Mexico.

DoD Partnerships: They have a sharing agreement with DoD but must renegotiate that agreement with each new base commander.

Staff shortage: They are short doctors, nurses and technicians. They have 29 employees currently activated in the National Guard or Reserve.

Emergency room: The ER is VA-staffed, open 24/7, and treats approximately 60 veterans each day.

Long-term care/mental health/homeless: They have a long-term care program. They have palliative-care and respite-care programs. They send Alzheimer's and dementia patients to nursing homes. They have a lockdown psychiatric unit and 8,500 unique mental-health patients enrolled. They provide assistance to 450 homeless veterans.

Fourth Mission: They are a primary-care receiver for the military and are involved in local homeland security planning.

VA Sierra Nevada Health Care System
Reno, Nev.
May 29, 2003

Demand and Delay: They treat approximately 22,727 veterans with 178,559 visits per year. They have 13 veterans waiting 28 days for an appointment. They have 350 new veterans applying each month.

Funding: The budget this year is $88.3 million. Third-party reimbursement target last year was $5.2 million. They collected $6.2 million and their new target is $8.4 million.

Affiliations/partnerships: They have affiliations with the University of Nevada and the University of California.

Staff shortage: They are short on doctors, especially specialty doctors. They are also short on nurses. They pay retention and signing bonuses. Nurses work overtime. They are short on pharmacists as well. They have 25 employees in the National Guard and Reserves.

Emergency room: The ER is open 24 hours a day and staffed during daytime hours by VA and nights and weekend through contracted care. They treat approximately 32 veterans each day.

Long-term care/mental health/homeless: They have 60 long-term care beds and no Alzheimer's or dementia beds. They have a hospice program. They care for 3,200 mental-health patients and 400 homeless veterans.

Fourth Mission: They are secondary receiver for military casualties. They have a local community homeland-security program.

VA Central California Health Care System
Fresno, Calif.
June 2, 2003

Demand and Delay: 254 veterans are waiting 57 days for their first primary-care appointment. Growth in patient population has been 14 percent in four years. They have four primary-care teams. Each team treats 40 veterans each day. They average 35 new Priority Group 8 veterans applying each week. They have had 867 Priority Group 8 veterans apply since January.

Funding: The budget was $86 million for FY 2002. Third-party reimbursement target was $3.5 million. They collected $3.51 million. Their new target is $4.7 million.

Affiliations/partnerships: They have affiliations with the University of California and 40 other schools.

DoD Partnerships: They have a DoD sharing program for MRI services.

Staff shortage: They contract some specialty-care doctors. They offer finder's fees and retention bonuses. Some overtime required. They have 26 employees who also serve in the National Guard or Reserve.

Emergency room: They have no ER but do operate an intake evaluation service that operates 24 hours a day and is VA-staffed.

Long-term care/mental health/homeless: They have no Alzheimer's unit. They do treat Alzheimer's patients but do not provide rooms. No hospice or hoptel.

Fourth Mission: They are a secondary receiving site for military casualties and participate in local homeland security plans.

Overton Brooks VA Medical Center
Shreveport, La.
June 19, 2003

Demand and Delay: Wait times for veterans who are 50-percent or less service-connected disabled is 90 to 110 days. Wait times for those veterans is 50 percent or higher is less than 30 days.

Funding: FY 2002 budget was $109 million. FY 2003 budget was $128 million. Third-party collection target was $8.8 million; $9.3 million collected. FY 2003 third-party collection target is $11.2 million.

Affiliations/partnerships: Affiliation with Louisiana State University Health Science Center.

DoD Partnerships: Agreement with the Air Force base and must renegotiate with each change of command.

Staff shortage: They are short specialty doctors and technicians. They historically have difficulty recruiting and retaining pharmacists. They have 27 employees who also serve in the National Guard or Reserve.

Emergency room: ER treats on average 11 patients per weekday and 10 patients per day on weekends. Total admitted each day is three.

Long-term care/mental health/homeless: They have no Alzheimer's unit and no hospice or hoptel. They treated 162 homeless veterans last year. They are currently treating 4,000 unique mental-health patients.

Fourth Mission: They are a primary receiving site for military casualties and participate in local homeland security plans.

[From the Pittsburgh Post-Gazette, July 15, 2003]

AMERICAN LEGION ASSAILING VETERANS ADMINISTRATION HOSPITALS, CLINICS

(By Jack Kelly, National Security Writer)

Veterans Administration hospitals and clinics are under funded and understaffed, and veterans feel betrayed, the American Legion plans to say at a news conference in Washington, D.C., today.

Ronald Conley, national commander of the American Legion, will issue a report on his visits to more than 50 VA hospitals and clinics and his conversations with thousands of doctors, nurses, veterans and family members of veterans.

"From nearly everyone, I found acute frustration about the lack of timely access to VA health care, under-use of some facilities, overcrowding in others, and inconsistent budgets and budget expectations," Conley's prepared statement says. Conley is a resident of Scott but none of the medical facilities mentioned in his statement are located in southwestern Pennsylvania.

With 162 hospitals, 850 clinics, 137 nursing homes and 43 domiciliaries, the Department of Veterans Affairs runs America's largest medical system. The number of veterans being treated at VA facilities has more than doubled since 1998, from 2.9 million to 6.8 million. About 25 million veterans are eligible for VA care.

Veterans with service-connected disabilities and those with serious ailments go to the head of the line. But veterans with disabilities unrelated to their military service often must wait up to 6 months for treatment.

Backlogs are uneven. More than 10,000 veterans wait for treatment at the VA facility in Bay Pines, Fla., but the VA hospital in Jackson, Mississippi, just 750 miles away, offers next-day service.

Conley is critical of a cost-saving measure instituted by Veterans Affairs Secretary Anthony Principi. This year, veterans with nonservice-connected disabilities and incomes of $36,000 or more a year are not eligible for treatment at VA hospitals. The policy will be reviewed at the end of the fiscal year.

Principi is breaking a promise America made to veterans, Conley said. "A veteran is a veteran. Anyone who raised an M–16 in basic training, ran five miles in boots and packs, rappelled from a helicopter into an ocean, or discovered firsthand what it means to fix bayonets meets the criteria.

There should be a mandatory appropriation model for VA medical care, similar to what exists for Medicare, Conley said. He acknowledged *this* would raise costs of running the VA medical system far beyond the 7.7 percent increase President Bush has proposed, But Conley said veterans deserve it.

"The government always seems to produce billions for foreign aid, millions for pork-barrel projects that range from restoring statues of mythological gods to subsidizing Elvis impersonators . . . and always enough to keep sending young men and women off to fight our government's battles in foreign lands," Conley said.

[From the Los Angeles Times, July 15, 2003]

VA HEALTH SYSTEM FAILING, SURVEY SAYS

(By Susannah Rosenblatt, Times Staff Writer)

VETERANS HAVE TO WAIT UP TO HALF A YEAR FOR AN APPOINTMENT, THE AMERICAN LEGION REPORTS. CLINICS CAN'T KEEP UP WITH DEMAND

WASHINGTON.—Veterans are waiting 6 months or more for medical care as a severely overburdened Veterans Affairs health system fails to keep pace with growing demand, a report to be presented to Congress today concludes.

"Washington, D.C., operates on a mentality of statistics," said American Legion national commander Ronald Conley, the author of the report.

"We wanted to make everybody aware that these are not just numbers, but are actual, real people and they're sick and they need to see a doctor and they can't wait."

An estimated 110,000 veterans are waiting for initial appointments for nonservice-related medical problems at hundreds of VA centers around the country, the VA acknowledges.

Conley is scheduled to testify today before the Senate Veterans' Affairs Committee.

The VA expects to see 4.7 million veterans in its hospitals and clinics this year, up more than 54 percent from 1996. The rising cost of private health insurance and prescription drugs have led more veterans to rely on VA medical care. About 7 mil-

lion of the nation's 25 million veterans, or 28 percent, are receiving VA medical benefits.

"A lot of people who may have been able to afford health insurance in the past are finding it difficult to afford it," said David Autry, a spokesman for Disabled American Veterans. "They are turning to VA, where they feel their country should take care of them."

Dr. Robert Roswell, VA undersecretary for health, said he also attributes the influx of patients to new VA community clinics and improvements in the quality of care. The waiting list for appointments had been considerably longer, he added, with 315,000 veterans on it just last summer.

President Bush's 2004 budget allots $27 billion for VA health care, an increase of 7.7 percent from last year, Roswell said. "We're quite pleased with the support the President has shown," he said, but the funds are still not enough to "keep pace with truly phenomenal growth."

The chairwoman of a Presidential task force that examined the VA health system in 2001 agreed with veterans' groups that the system is unable to meet patients' needs.

"It was very clear that there were not enough resources currently available to fund services for veterans in a way that would allow them to get health care without undue delay," said Gail Wilensky, now a senior fellow at Project HOPE, a health-care advocacy group.

The American Legion's Conley visited 60 VA medical facilities over 10 months, talking to hospital directors, doctors, nurses and patients to assess how well the system meets patient demand.

The 162 hospitals, 850 clinics and 137 nursing homes that constitute the nation's largest managed-care system are chronically under funded, his report concluded.

The VA Greater Los Angeles Health Care System, one of the largest in the country with 12 outpatient clinics and an operating budget of nearly $500 million, was not included in the report and a spokesman there declined to comment.

Veterans' groups are calling for a change in the way VA health care is funded, so that it would receive a guaranteed stream of income much like Medicare already does.

Currently, each year's VA spending must be set by Congress, making it subject to the constraints of the overall Federal budget. Such unpredictability makes it difficult for hospitals and other facilities to operate, Conley said.

"No matter what the number is that may actually be needed, there is no guarantee that that amount of money will be provided in the end," Autry said. "The VA doesn't have enough money to begin with, we can't plan from month to month and we don't know when we're going to get this money and how much it's going to be."

In 1996, Congress relaxed eligibility requirements for VA health care, allowing more veterans to enroll. A generous prescription benefit is one reason that many have for enrolling. The VA offers a 30-day supply of each medication for a $7 co-payment.

The President's budget includes provisions to increase the co-payment to $15 for higher-income veterans and eliminate it for those with lower incomes. The budget also proposes a $250 enrollment fee for higher-income veterans.

An American Legion survey last year of about 4,000 veterans found the average wait for an appointment is 7 months and that 58 percent had appointments rescheduled, many for several months later.

"All I did was put in 20 years of separations, hardships, sacrifices," wrote one survey responder, Robert Thomas, who served in Korea and Vietnam in the Navy.

"The thanks I received is to be told that it will be another year before I see my first VA doctor."

Chairman SPECTER. Commander Conley, I want to ask you just a couple of questions relating to your statements about mandatory funding. If VA were to have been so funded this year, it would have a 1.4-percent increase this year. But instead of that, the VA requested an increase of 5.8 percent, and the Congress increased VA medical care funding by some 11.3 percent. While the veterans appropriations, I agree with you, have not been adequate, we have been able to do better even than the administration that is a great friend of the veterans.

What would your thinking be considering the larger amounts made available through the discretionary approach as opposed to the 1.4 percent, which would have been the mandatory increase?

Mr. CONLEY. Well, Senator, first of all, the budget included $2.1 billion in third-party reimbursements. Under the mandatory funding, the third-party reimbursements should not come into play. If you take out the increase that the administration is asking for on a fee basis for prescription and the enrollment fee that they are proposing, if you take all those out of the budget, there really was not an increase as far as VA health care. The mandatory funding would actually give you the real dollars necessary for health care, plus you can then add on the additional amounts of money.

What is happening now, the directors are greatly stressed in two areas: One is to be able to collect third-party reimbursements. I don't know what formula was used on how to increase that amount of money by each hospital. The second is a lot of hospitals, including VISN's, have to dip into their capital investment money in order to take care of the health care of those veterans. So now they don't have any money that they can go out and buy new equipment and fix the roof and keep the facility from deteriorating because they need to do it to hire doctors and nurses.

Chairman SPECTER. Let me shift gears, Commander, to the issue of the veterans who are enrolled for VA care in order to get VA pharmaceutical benefits.

Legislation has been introduced, Senate bill 1153, which provides that you wouldn't have to become an enrollee in the VA in order to get Medicare doctor-written prescriptions filled by the VA without first having seen a VA physician. If the veteran wanted to enroll, fine, he could. But if veterans are enrolling solely to get the prescription benefits, it wouldn't be necessary for them to enroll. That might ease the burden on the VA, but still leave the veteran with what the veteran is really looking for, and that is, the VA prescription program.

Do you think Senate bill 1153 is a good idea?

Mr. CONLEY. Well, what I think on that, Senator, one, is the liability if the VA is just going to hand out prescriptions and become a drug store without having the veteran seeing a doctor. I think probably the easiest way to do this is if you have Medicare reimbursement, Medicare subvention, then you would have a one-stop shop where the veteran would go to the VA, see the doctor, get his prescription filled, and that would take care of it. But if you are going to go from outside the system and just have the VA become a drug store, I think it is something the American Legion has to seriously take a look at.

Chairman SPECTER. Well, I agree with you, Commander, on the idea of Medicare subvention. I think that is a good idea. We have been trying to push that, and also third-party insurance payments ought to go directly to the VA installation where the service is performed to give a boost to funding available.

But when the veterans would come with their prescriptions, they would have already seen a doctor. I agree with you that you should not dispense prescriptions without a medical authorization. But that having been achieved, we would appreciate your further consideration.

Note that I ended with 1 second left, Ron.

Mr. CONLEY. Yes.

Chairman SPECTER. Senator Bunning.

Senator BUNNING. Thank you, Mr. Chairman.

Mr. Conley, you said some good things in your testimony about VA affiliation with medical schools. Do you think that the VA should be actively increasing their dealings with medical schools?

Mr. CONLEY. Absolutely. One of the things that I was able to notice, first of all, with affiliation with schools, it brings research money into the VA, and I was just in Oklahoma and they received a total of $4 million—or $6 million in research money. Two million of that comes out of the VA budget. The rest of it is from outside grants that they invest into the research program.

You are also able to achieve probably the best physicians in the world that work at the VA because of their associations with the medical schools. Over 50 percent of doctors in our country have been trained through the VA. So we see so many things that are positive about it.

Some of the hospitals, such as Oklahoma, they end up paying part of the physician's pay because the VA cannot afford to pay the salaries that some of these physicians require. So the schools themselves then pick up their salaries.

The thing that greatly disturbs me about Chicago is that Northwestern University has gone out of their way to try to keep a hospital there by offering a whole hospital to the VA for free. All they have to do is maintain it. They give them 300 doctors at no cost to the VA a year to help keep their population down, but the VA turned that request down. That is something I am having a hard time understanding.

Senator BUNNING. Well, what was the explanation of the Veterans Administration? Have you approach them on that?

Mr. CONLEY. Yes, sir, and we do not have an explanation. If you go through—we have the full records of my visits to these hospitals, and——

Senator BUNNING. Well, could you make that specific connection between Northwestern University and the VA hospital in Chicago, the report on that? Is that part of your report?

Mr. CONLEY. Yes, sir.

Senator BUNNING. Okay. That is something that I will get into. I have not read that portion.

Mr. CONLEY. Well, if it is not in there, it should be.

Senator BUNNING. It should be.

Mr. CONLEY. It should be in there.

Senator BUNNING. Okay. Let me ask you a further question. Do you think that the VA should locate new facilities near medical school campuses when possible? In other words, I know where the VA hospital is in Louisville, for instance, and that is not near any medical school in the Louisville area because one is in eastern Jefferson County and the other one is in southern Jefferson County.

If, in fact, we were to get the ability to locate a new VA hospital or a facility in Louisville, it would behoove us to move it a lot closer to the University of Louisville where the medical school and the doctors are more available for training? Was it my understanding of what you said that 50 percent—did you just make the statement

a minute ago that 50 percent of the training of doctors in our medical schools have some relationship to the VA?

Mr. CONLEY. That is correct.

Senator BUNNING. That is also in the report, I assume.

Mr. CONLEY. That should be in there. But that is correct. The number of doctors in our country, at least 50 percent——

Senator BUNNING. Either had something to do with the VA hospitals or were trained and spent time as an intern or whatever it might be.

Mr. CONLEY. Yes. Steve just mentioned the senior member of the Republican Senate is an example who was trying——

Senator BUNNING. Ted Stevens.

Mr. CONLEY. Senator Frist.

Senator BUNNING. Well, Ted is the Senior Member of the Senate, isn't he? Yes, Ted Stevens. You are talking about the Leader.

Mr. CONLEY. Majority Leader.

Senator BUNNING. Majority Leader, okay. He is not the oldest guy in the Senate, though.

[Laughter.]

Senator BUNNING. I think the satisfaction of veterans who are actually receiving care speaks well for the changes made in the VA in recent years, especially in the quality of the care, as you mentioned. But, unfortunately, the VA is often unable to recruit and retain many of our best doctors and nurses because of salaries and other issues.

When visiting the medical centers, what did the doctors and nurses and other personnel have to say to you about their working conditions? What did they say could help improve those conditions and their jobs? This is my last question.

Mr. CONLEY. I don't want you to repeat that again, but how they can improve——

Senator BUNNING. In other words, in talking to the doctors, nurses, and other personnel, what was the main thrust how their job conditions and the improvement in the health care facilities that they are providing for the veterans in, how can we do better and make their jobs easier and more functional?

Mr. CONLEY. By being able to hire more doctors and nurses. A lot of them are placed under stress because of having to work overtime in order to fulfill that commitment.

When I visited Togus, Maine, Senator Snowe traveled with me, and this was reported to her, not to me, as we walked through the hospital. A patient came up to Senator Snowe and said that the nurse was just getting ready to dispense medication to him again for the second time. The reason was that she was totally exhausted from working overtime that she forgot that she already dispensed that medication.

So the care is good, and that is just one incident off the side. The quality of care was excellent wherever I went. The problem is that they are under a lot of stress because of so much overtime or there is not enough nurses, doctors, or technicians to fulfill the need of giving that care.

Senator BUNNING. Thank you, Mr. Chairman.

Chairman SPECTER. Thank you very much, Senator Bunning, and thank you, Commander Conley, thank you, Mr. Robertson, Mr.

Gaytan, and Mr. Spanogle. Thank you, ladies and gentlemen, who have come here to hear the Commander's testimony.

Mr. CONLEY. We want to thank you, too, Senator.

Chairman SPECTER. Thank you.

That concludes our hearing.

[Applause.]

[Whereupon, at 3:21 p.m., the committee was adjourned.]

APPENDIX

PREPARED STATEMENT OF HON. BOB GRAHAM, U.S. SENATOR FROM FLORIDA

Thank you, National Commander Conley and the American Legion for both your testimony and your report on the condition of VA health care in America. You are to be congratulated for your "I am Not a Number" Campaign. Waiting times for both primary and specialized care remain abysmal, but you've managed to put a very real face on the problem.

For example, one veteran profiled in the American Legion report from Arcadia in my home State of Florida, detailed his plight in trying to obtain his first doctor's appointment at the Fort Myers VA Medical Center. He describes how despite applying in early 2000, he was not enrolled until December of 2001, and has been waiting another whole year to be scheduled for his first appointment. He spent 20 years in the military, which included service in both Korea and Vietnam. It is truly shameful that veterans are being treated this way by the very system designated to take care of them following their service to this country.

The Administration has chosen to blame Congress for the long waiting times. Officials blame Congress for opening up VA's doors—in 1996—to all eligible veterans. This move is known as "eligibility reform1" and was done to correct the problem described in Commander Conley's testimony. Prior to eligibility refom1, the Veterans Health Administration operated under a very complex system. As Commander Conley's testimony points out, "There were no defined health benefits packages, no reliable data projecting future patient population . . . Access to the system was severely limited to only three groups of veterans: service-connected disabled veterans, other disabled veterans, and economically indigent veterans."

For years, when we looked at the VA health care system, we focused on the declining veteran population and declining demand. We are in a totally different predicament today. More veterans are turning to the VA health care system, and that is a success story.

There can be little doubt that the proposed funding for medical care in the President's budget is below the amount needed to fully fund the system. Veterans Service Organizations estimate that "the President's budget is, at a minimum, some $2 billion below what is required to assure veterans the health care services they earned in military service."

In addition, the Administration's approach to deal with burgeoning numbers is to directly reduce demand by cutting off enrollment to higher-income veterans and to artificially reduce demand

by impinging new deductible and cost sharing requirements on those already enrolled. This is unacceptable.

In my view, the only real path—the path that reflects the true sacrifice of our veterans—is to own up to the demand for health care services and provide funding. I am pleased that the Conference Report on the Budget Resolution approximates the increase for VA health care recommended by the consortium of veterans' services organizations that author the Independent Budget for Fiscal Year 2002, and I will work to make these numbers real.

Commander Conley also discusses the CARES process in his testimony. CARES is designed to better prepare VA to serve veterans in the future, and I totally support this kind of examination of VA care. But, it is absolutely critical that this be done right because there is too much at stake. So far, I have been disappointed in CARES because of the lack of attention to the future health care needs of veterans, including long-term care and alternatives to nursing home care. As Commander Conley points out, despite the incredible demand for long-term care, VA has chosen to ignore it in its planning for the future.

I remain adamant that when considering the future of VA, a key factor must be the aging veterans population. Right now, there are 10 million veterans over age 65. Even the number of veterans age 85 or older will double by 2012. Given these demographics, I am as perplexed as Commander Conley as to why the demand for long-term care has been ignored.

Another serious concern is that VA appears to be manipulating the CARES process. In early June, 20 facilities submitted their recommendations to VA as part of the process, but were subsequently requested to re-evaluate their plans in order to find a way to move from 24-hour operations to 8-hour-a-day clinics. Not only does this action appear to target long-term care beds in particular—since these 20 facilities currently house thousands of veterans in need of long-term care—but it also appears to be a significant manipulation of the CARES process.

As ranking member of the Senate Committee on Veterans' Affairs, I appreciate your insights into the challenges of VA's health care system. While the problems may seem significant, I am confident that we can work together to improve VA health care for all veterans. Veterans are depending on us.

Thank you.

○