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RESTRUCTURING VA MEDICAL SERVICES: MEASURING AND MAINTAINING THE QUALITY OF CARE

HEARING

BEFORE THE

SUBCOMMITTEE ON HUMAN RESOURCES

OF THE

COMMITTEE ON GOVERNMENT REFORM AND OVERSIGHT

HOUSE OF REPRESENTATIVES

ONE HUNDRED FIFTH CONGRESS

FIRST SESSION

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RESTRUCTURING VA MEDICAL SERVICES: MEASURING AND MAINTAINING THE QUALITY OF CARE

MONDAY, AUGUST 4, 1997

HOUSE OF REPRESENTATIVES,
SUBCOMMITTEE ON HUMAN RESOURCES,
COMMITTEE ON GOVERNMENT REFORM AND OVERSIGHT,
Middletown, NY.

The subcommittee met, pursuant to notice, at 1 p.m., in Walkill Community Center, Middletown, NY, Hon. Christopher Shays (chairman of the subcommittee), presiding.

Present: Representatives Shays, Gilman, Kelly, and Hinchey.

Staff present: Lawrence J. Halloran, staff director and counsel; Robert Newman, professional staff member; and R. Jared Carpenter, clerk.

Mr. SHAYS. I call this hearing to order. This is a hearing of the U.S. Congress. I apologize for the number of people who have to stand. This is a field hearing of the House of Representatives. We are going to demand absolute order in these hearings.

Our witnesses are to be sworn in until we get to the third panel, and I'll clarify that in just a second. I would like the chief to make an announcement since——

Audience PARTICIPANT. Who are you, sir?

Audience PARTICIPANT. Who are you?

Mr. SHAYS. Let me just be very clear. I will adjourn this hearing at a moment's notice if we do not have order. There is to be no catcalling. There is to be no response from the audience. This is——

[Chorus of boos.]

Audience PARTICIPANT. We don't want to be treated like babies. [Applause.]

Mr. SHAYS. Chief, do you want to make an announcement?

Mr. COSCETTE. Yes. Good evening, everybody. My name is Chief James Coscette.

We're not here to fight or go against you. I, myself, am a veteran. I'm proud to have you people here. And I'm sure the board will listen to what you have to say.

My job here is the crowd capacity here in this Town Hall.

My officers are here to help you and assist you. Please let us remain a calm, cool, collective, bargaining people, as yourself. You've done your time. You've represented us. And I thank you all for being here.

The exits are at the front here, in the rear, and in the back. Please, ladies and gentlemen, keep the aisles clear for all people wanting to come up and speak.

Thank you.

Audience PARTICIPANT. All right. A question was asked to the gentleman. All they wanted to know is who he was.

Audience PARTICIPANT. That's right.

Audience PARTICIPANT. That's all.

Audience PARTICIPANT. It's supposed to be a secret.

Mr. SHAYS. Let me just welcome all of our witnesses. I'd like to welcome our guests as well.

Audience PARTICIPANT. Who are you? Who are you?

Audience PARTICIPANT. Who is speaking to us?

Audience PARTICIPANT. That's my question.

Mr. SHAYS. This is the hearing of the Government Reform and Oversight Committee, the Subcommittee on Human Resources. We're the committee that oversees the Departments of Health and Human Services, Housing and Urban Development, Education, Labor, and also the Department of Veterans Affairs for waste, fraud, and abuse.

This is the committee's first field hearing that we've had this year. And we're having it at the request of the three Congressmen you see seated next to me. The purpose of this hearing is to look at the quality of care of the Veterans Administration in this district and to consider whether the quality of care is improving or declining. We will stay and hear all our witnesses.

My name is Christopher Shays. I am the chairman of the subcommittee.

This is the same committee that has had 10 hearings on the Gulf War Syndrome. This is the committee why you know of Kamisiyah and why you know of some other problems in the Persian Gulf. We have been very active in veterans' affairs.

We are here at the request of your three Congressmen because you have asked for this hearing. And we welcome you here today. But this is an official hearing of Congress. We have to have order. I really request that you provide us that order.

And at this time, I would recognize Ben Gilman.

Mr. GILMAN. Thank you, Mr. Chairman. [Applause.]

I want to welcome all of our veterans who have taken the time out of their busy lives to be with us today. I want to welcome also our Veterans Administration officials who are here. We have Mr. Farsetta, who is the regional director. We have Maryanne Musumeci, who is also a regional director, now the head of the Bronx VA hospital. We have Mr. Sabo, who is the new Castle Point director. And we have Dr. Nancy Wilson, who is one of the program directors with the Veterans Administration. We thank our panelists for being here with us.

Can you hear us in the back all right?

[Chorus of yeses.]

Mr. GILMAN. And I'm pleased that we're joined here with Congresswoman Sue Kelly, who represents a portion of this county and other adjoining counties. And Congressman Maurice Hinchey represents the areas north of us and also a portion of Orange County. [Applause.]

And I urge you, please, give respect to our panelists and to our witnesses. And we're going to try to move along as quickly as we can.

If I might, Mr. Chairman, I'd like to give an opening statement at this time. Our fellow veterans and ladies and gentlemen, I want to, first of all, express a great deal of gratitude to Congressman Chris Shays for willingness to arrange this hearing, to take time out of his schedule, to be over here in our area to address a very serious concern that we all have and to hold it in a forum that is accessible to our local veterans.

As the ranking Republican on the Government Reform and Oversight Committee, I approached Chairman Shays last May and requested that his subcommittee initiate an investigation into the quality of care being delivered at Castle Point and at Montrose. I did this because we were not satisfied with the manner in which the VA was responding to the concerns of our veterans and their families who had come forward with their health care complaints.

It's my opinion that it was the Veterans Administration's lack of compassionate response to the veterans' complaints that poisoned the atmosphere and eliminated a great deal of hope for a workable solution with our veterans in our local communities. Their concerns were obviously not being addressed adequately, and we felt that the congressional intervention was warranted.

And many of you have probably heard of the plan developed by the VA to shift funding to geographic areas that have inadequate resources to meet their level of demand. This plan that was known as the Veterans Equity Resource Allocation Model, known as VERA, has resulted in health care funds flowing away from New York State to places like Arizona, Mississippi, and California.

By now you're all undoubtedly aware that we have major philosophical disagreements with the proponents of that VERA program in both the Congress and the administration. I believe this plan is ultimately harmful to the veterans of the Northeast and, despite all assurances to the contrary, could result in a decrease in the quality of care provided. We hope that that will not be the ultimate result.

The watch word for VERA has been "efficiency." And, while we agree that there is a great deal of fat within the VA that needs to be trimmed, I would remind you that efficiency is not an unmitigated good. It's possible to go too far in scaling back services in the name of efficiency.

We've heard much in the last year about the need for the Veterans Administration to model private sector health care. To a certain extent that may be needed, but the private sector example is certainly not a panacea to all of our problems.

Many of you have heard some of the horror stories about HMOs that have cut back too far in quality care and place the bottom line on profitability before patient care. That certainly must not be allowed in our Veterans Administration facilities.

Unlike other so-called entitlements, veterans' health care benefits were earned through blood and sacrifice. And, for that reason, the Veterans Administration has a public duty to our veterans and to the American taxpayer to deliver health care that's equal or superior to that in the private sector.

The Veterans Administration is, in essence, the steward of our veterans' health. In maintaining that stewardship, the VA should not repeat the mistakes of the private sector with the streamlining of health care.

We intend to keep a close eye on the quality of care which the VA delivers in Network 3. And that's our own region, especially in the area of specialty care. And what we have seen so far has not been encouraging.

As I have noted in the past, the Veterans Administration has a major credibility problem with our New York congressional delegation and with the veterans that use both Castle Point and Montrose. The evidence from this past spring shows that this network and its administrators forgot about the human side of VA health care. And we have no illusions that it was only public exposure and the threat of congressional intervention which forced them to reevaluate their positions.

Regarding the general public, the VA response to those whose complaints appeared in the paper was, "Left a lot to be desired." Those stories may very well have been anecdotal, but it was grossly irresponsible for the hospital and the VISN officials. To publicly state so simply because each complaint was unable to be immediately verified did not make them any less important.

The tactic of dismissing patient and family experiences as unimportant certainly was counterproductive and gave the appearance that the VA had something to conceal. If nothing else, the officials of Network 3 owe these veterans and their families an apology for the treatment they did receive when they came forward.

It has also been the distressing trend of some VA officials in Washington to consistently attempt to shift the fault for this situation over to the Congress, stating that the Congress had underfunded VA health care in the past. These charges had been leveled despite the fact that the Congress traditionally meets the President's request for health care funding and, as a matter of fact, gave the Veterans Administration more funds than ever before in last year's budget. In fact, last year VA officials testified that they did not want any additional funds for this fiscal year.

The administration has proposed a flat budget until the year 2002, which will treat up to 20 percent more veterans. The VA claims that that's possible without any additional funds due to savings from efficiencies and retention of third party reimbursements. That remains to be seen. We hope that they will be able to retain those third party reimbursements, and we're trying to make that possible through statutory language.

So we in the Congress have repeatedly stated that we're willing to work with the Veterans Administration to address the ongoing issues of quality of care. And if more funds are needed to assure proper care, we want to know about it and we're going to try to help them get the kind of funding they do need.

Moreover, those of us in the Congress may often have some significant ideas which do warrant experimentation. For example, last week I suggested to Dr. Kizer, the Medical Programmer in the VA, and Secretary Gober, our new Administrator, that Castle Point should contract out with local hospitals for inpatient surgical procedures, rather than transporting patients all the way to Albany or

the Bronx, which incurs needless costs—[applause]—and which places undue stress on our veterans. Secretary Gober agreed to work with us on that issue as well as on doctor certification. And we hope to hear more about those subjects today.

So, in closing, let me say that it's our hope that this hearing today—and I speak on behalf of my fellow Congressmen over here—will serve as a first step toward improving the strained relationships between Castle Point and its patients.

And we look forward to the release of the report detailing the findings of the medical examiner's investigation of Castle Point as well as the results from a study that Congress is requesting from the Government Accounting Office on the effects of VERA.

In the interim, I hope that those of you who have come forward with specific problems about care at Castle Point will have your situations either rectified or, if this is not possible, receive just and proper compensation.

Again, we thank you for being here. We're here to try to resolve problems. Let's try to work together in those directions. Thank you, Mr. Chairman.

Mr. SHAYS. Thank you, Mr. Gilman. [Applause.]

This hearing was at the request of Ben Gilman, who I failed to mention is a member of this subcommittee besides being chairman of the International Relations Committee; also, Sue Kelly, on the Republican side of the aisle.

Mr. Hinchey, on the Democrat side of the aisle, as well, has expressed bipartisan concern about this issue. And at this time I'd like to recognize him.

STATEMENT OF HON. MAURICE D. HINCHEY, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF NEW YORK

Mr. HINCHEY. Thank you very much, Mr. Chairman. And good afternoon, ladies and gentlemen, and welcome to this hearing. I also want to welcome and thank our chairman, the chairman of the subcommittee, Chris Shays, who represents a congressional district in Connecticut, for holding this first field hearing on this subject here in our area in the mid-Hudson Valley. We appreciate your coming here. We want you to feel welcome. We know that you are joining us in a resolve to solve this problem on a bipartisan basis, and we very much appreciate your being here.

I want to say also that this hearing is held in honor and respect of the service and sacrifice of American veterans, and I want everyone in the audience to understand that. That is why the committee is here. We are determined and resolved on a bipartisan basis to ensure that the quality of care that is afforded for veterans improves and that it maintains the highest standard possible.

Mr. Chairman, I have a longer statement that I will submit, but I have a precis of it that I would like to read into the record at this time.

Mr. SHAYS. Sure.

Mr. HINCHEY. I believe we would all agree that the purpose of the veterans' health care system is to assure our veterans that they will always have access to quality health care. That has changed and evolved over the years, as it should, but that commitment remains its core purpose.

Today many veterans do not come to the VA for health care, often because they do not need to and sometimes because it is inconvenient and sometimes, unfortunately, because they have lost confidence in the ability of the VA to provide the kind of health care that they need. [Applause.]

They use non-VA facilities. The cost is often covered by Medicare or by employer-paid insurance. The VA now recognizes that it is not always convenient or appropriate to provide care at its hospitals and has begun developing outpatient clinics and other means of providing services to veterans closer to home. I think the VA deserves to be commended for this effort, but that is not justification for allowing the quality of care at VA health care facilities to decline.

That should not mean that the commitment to provide quality health care at its own hospitals should be relaxed or abandoned. The VA hospitals should continue to provide quality services to those veterans who continue to need those services.

I am deeply concerned that, for whatever reason, the quality of care at Castle Point has deteriorated. There is no question that many of our veterans in this area have lost their confidence in Castle Point and to a considerable degree in the VA itself.

Audience PARTICIPANT. Did your wife die there? Mine did.

Audience PARTICIPANT. That's true.

Mr. HINCHEY. All of us who are here today and who represent veterans in the Hudson Valley have lodged numerous complaints with the VA about the situation at Castle Point. We have had numerous meetings about Castle Point with VA Administrators, up to and including Secretary Brown and now Acting Secretary Gober. I think it is fair to say that we know our complaints have been heard, we know that the VA is paying attention, but we do not know if the problems are being resolved in a way that addressees the needs and concerns of the veterans that Castle Point is supposed to serve.

In my written statement for the record, I have included several detailed case histories of serious problems that some of my constituents have encountered at Castle Point. I want to emphasize that the cases in my statement represent only a small sampling of the many complaints that I have received.

I have been deeply disturbed not only by the number of complaints but also by the wide range of problems that have been reported to me through my office. They include allegations of: misdiagnosis by health care personnel, particularly doctors; errors in treatment; and surgical mistakes that suggest serious incompetence. They include complaints about poor relations between doctors and patients and the inability of doctors to communicate effectively with patients, a problem that Under Secretary Kizer—[applause]—a problem that Under Secretary Kizer confirmed in our most recent meeting. With regard to those complaints, I can announce to you today that the Members of Congress seated at this table have just introduced legislation that I have written—we have introduced it on a bipartisan basis—which will require that all doctors providing health care at VA facilities must be licensed to practice medicine in the State in which the VA facilities are located. [Applause.]

We will also require in this legislation that vital statistics, including death records, be filed with the appropriate State agency, including the State health department, and not be restricted only to the VA itself in the future. [Applause.]

I want to emphasize that this legislation is being introduced by the members of the committee seated here, Democrats and Republicans, on a bipartisan basis.

The complaints that I have received are about shortages of professional nursing staff and allegations that patients have been neglected as a result of these shortages. I have heard allegations as well about unsanitary conditions, poor maintenance of the facility, and the misapplication of funds.

Many of our veterans have expressed concern that the VA may be ignoring these problems because it is concentrating too much effort on more abstract management issues; most importantly, the shift of funding known as VERA, which Mr. Gilman mentioned a few moments ago.

The VA has told us repeatedly that VERA would not reduce services or compromise quality of care at Castle Point, but that is what seems to be happening. Services has been reduced. Quality has been compromised.

Under Secretary Kizer recently told us that there were notable problems at only four VA facilities that were being consolidated, but he did not include Castle Point on that list. We want to make it clear that we believe the problems at Castle Point are, in fact, quite notable and need to be addressed vigorously and immediately.

Audience PARTICIPANT. "Notorious" is the word.

Mr. HINCHEY. I want to make it clear that I believe these problems need to be straightened out.

As the committee knows, I have requested that the VA's Inspector General conduct a thorough investigation of the problems at Castle Point, including reports of an increased mortality rate, declining quality of care, quality and adequacy of the staff, and the effects of resource allocation on Castle Point. We will be eager to see that study when it is completed.

My office is making available to the Inspector General specific case histories that have come to our attention so that the Inspector General will be able to direct the attention of his office to those specific complaints and examine in detail specific cases where severe problems apparently have occurred.

We will be eager to see the study when it is completed. In the meantime, I hope the committee will consider some of the broader questions about government management and VA management itself that this situation has raised.

Specifically, these issues are some of the issues that concern me, and here they are. Is management of VA health care being driven by computer analysis and allocation formulas while actual day-to-day conditions and the concerns of individual patients and their families are being ignored? If so, we need to remedy that situation immediately.

Does the problem lie with applying uniform rules and standards and salary schedules across the country? Is it harder, for instance,

to find good physicians and nurses here in New York than, for instance, in Salem, VA or other places in the country?

Would the problems be alleviated if there were better communication between VA administrators and the veterans themselves? Is it possible to require clearer communications, as in the regulatory process, for instance? We have heard constant complaints that veterans' concerns are ignored, that they are not notified about changes in the services provided, and that they are not consulted adequately, even with regard often to their own care.

Finally, and perhaps most importantly, are the problems attributable to a shortage of funds? VA administrators have suggested this to us on several occasions, and I have asked several times if they need more money to provide the services veterans expect and deserve. We have not had an answer to that question.

Congress may be at fault here by imposing arbitrary budget ceilings. The Administration may be at fault in its budgeting process. We need to know the answers to these questions.

But if cold, hard budget decisions made in an analyst's office in Washington mean that a diabetic veteran in New York is left unmonitored and ignored, then the public needs to know that.

The Veterans Administration has suggested to us that this may be the case. We need to know the answers to these questions. And upon getting the answers to these questions, we need to ensure that these issues are dealt with adequately, forthrightly, competently, and completely. And that is the purpose of this hearing.

And, Mr. Chairman, I thank you for being here and giving us this opportunity. [Applause.]

[The prepared statement of Hon. Maurice D. Hinchey follows:]

Testimony of Congressman Hinchey
before the Subcommittee on Human Resources
House Committee on Government Reform and Oversight
August 4, 1997

I believe we would all agree that the purpose of the veterans' health care system is to assure our veterans that they will always have access to quality health care. It has changed and evolved over the years, as it should, but that commitment remains its core purpose.

Today most veterans do not come to the VA for health care, often because they do not need to and sometimes because it is inconvenient. They use non-VA facilities; the cost is often covered by Medicare or by employer-paid insurance. The VA now recognizes that it is not always convenient or appropriate to provide care at its hospitals, and has begun developing outpatient clinics and other means of providing services to veterans closer to home. I think the VA deserves to be commended for this effort.

However, that should not mean that the commitment to provide quality health care at its own hospitals will be relaxed or abandoned. The VA hospitals should continue to provide quality services to those veterans who continue to need them. I am concerned that--for whatever reason--the quality of care at Castle Point has deteriorated. There is no question that many of

our veterans in this area have lost their confidence in Castle Point, and to a considerable degree, in the VA itself.

All of us who are here today and who represent veterans in the Hudson Valley have lodged numerous complaints with the VA about the situation at Castle Point. We have had numerous meetings about it with VA administrators, up to and including Secretary Brown and Acting Secretary Gober. I think it is fair to say that we know our complaints have been heard, we know that the VA is paying attention, but we don't know if the problems are being resolved in a way that addressees the needs and concerns of the veterans that Castle Point is supposed to serve.

In my written statement for the record, I have included several detailed case histories of serious problems that some of my constituents have encountered at Castle Point. I want to emphasize that the cases in my statement represent only a small sampling of the many complaints I have received. I have been disturbed not only by the number of complaints, but also by the wide range of problems that have been reported to me. They include allegations about misdiagnosis, errors in treatment, and surgical mistakes that suggest serious incompetence. They include complaints about poor relations between doctors and patients, and the inability of doctors to communicate with patients--a problem

that Undersecretary Kizer confirmed in our most recent meeting. They include complaints about shortages of professional nursing staff and allegations that patients have been neglected as a result of these changes. I have heard allegations as well about unsanitary conditions, poor maintenance of the facility, and misapplication of funds.

Many of our veterans have expressed concern that the VA may be ignoring these problems because it is concentrating too much effort on more abstract management issues--most importantly, the shift of funding known as VERA. The VA has told us repeatedly that VERA would not reduce services or compromise quality of care at Castle Point--but that is what seems to be happening. Undersecretary Kizer recently told us that there were "notable problems" at only four VA facilities that were being consolidated--but he did not include Castle Point on that list. I want to make it clear that I believe that the problems at Castle Point are indeed "notable."

As the Committee knows, I have requested that the VA's Inspector General conduct a thorough investigation of the problems at Castle Point, including reports of an increased mortality rate, declining quality of care, quality and adequacy of the staff, and the effects of resource allocation on Castle

Point. We will be eager to see that study when it is complete. In the meantime, I hope the committee will consider some of the broader questions about government management and VA management that this situation has raised.

Specifically, these are some of the issues that concern me. Is management of VA health care being driven by computer analyses and allocation formulas, while actual day-to-day conditions and the concerns of individual patients and their families are ignored? If so, how can this be remedied?

Does the problem lie with applying uniform rules and standards and salary schedules across the country? Is it harder, for instance, to find good physicians and nurses here in New York than, for instance, in Salem, Virginia?

Would the problems be alleviated if there were better communication between VA administrators and veterans? Is it possible to require communications, as in the regulatory process, for instance? We have heard constant complaints that veterans' concerns are ignored, that they are not notified about changes in services provided, that they are not consulted.

Congressman Maurice Hinchey
August 4, 1997

Finally, and perhaps most importantly, are the problems attributable to a shortage of funds? VA administrators have suggested this to us on several occasions, and I have asked several times if they need more money to provide the services veterans expect and deserve. I haven't had an answer. Congress may be at fault here by imposing arbitrary budget ceilings; the Administration may be at fault in its budgeting process. I don't know. But if cold, hard budget decisions made in an analyst's office in Washington mean that a diabetic veteran in New York is left unmonitored and ignored, then the public needs to know that. The VA has suggested to us that this may be the case. We should try to find out.

Additional testimony of Congressman Maurice Hinchey
before the Subcommittee on Human Resources
House Committee on Government Reform and Oversight
August 4, 1997

A. General Remarks

1. Veterans were made certain promises about the care they would receive for service to our country and it is the responsibility of the government to keep those promises.

2. In the last decade the veteran's population has seen extensive changes that have affected their basic entitlement to health care within the VA system. While I understand that it is not the intention of this committee to redress all of those changes, it is this committee's responsibility to access the effect those changes have had on the veteran's community.

3. Although I understand that changes are taking place in health care delivery systems throughout the United States, the changes in the VA system should, in no way, adversely affect the quality of care or the range of services available to veterans in any community. Please be assured that while I fully support the mission of the VA to provide health care for our veterans, I am uncertain how this goal can be achieved if the veterans question the integrity of the services they receive through the VA, if the veterans question their right to receive the services and, if the veterans question the availability of services without having to travel 50, 75, or even 100 miles from their homes to receive treatment.

4. In recent months I have heard numerous complaints about both the quality of care as well as the reduction of services available at the two Hudson Valley VA facilities, Castle Point and Montrose.

5. The extent of these complaints calls into to question whether the VA is keeping its basic promise to provide quality, full service health care to veterans in the Hudson Valley and in other communities.

6. Veterans and their families have contacted my office with allegations of neglect, unsanitary conditions, misdiagnosis and errors in treatment as well as in surgical procedures. They have complained about poor doctor/patient relationships, the overall caliber of the doctors, shortage of nursing staff and reduction in services. They have made allegations that health conditions have deteriorated or, even worse, resulted in death, while under the care of these two facilities. They have shouted that the promises they were given are not being honored.

7. In a recent meeting, Undersecretary of Health, Kenneth Kizer, indicated that "notable problems" have occurred at only four VA hospital undergoing consolidation. Further, that Castle Point & Montrose were not among the four. This leaves room to question how far reaching quality of care issues are within the VA system if the complaints and allegations I have been given don't even rank as "notable".

8. I am not a physician, nor a hospital administrator. However, I am an elected representative, committed to serving the needs of my constituency.

It is my responsibility to ensure that their concerns, complaints and allegations are not brushed aside.

9. I have requested an independent investigation into these matters be conducted by the Inspector General of the VA. I am hopeful that the results of that investigation, in conjunction with the findings of this committee, will allow us to take appropriate corrective actions to ensure that veterans, regardless of the state they reside in, have access to, and that they receive, the highest quality health care available.

10. If it is determined that the problem lies with the quality of personnel, we must ensure that the doctor's, the nurses and other professionals working for the VA meet and, where possible, exceed the standards in the private sector. If it is determined that these problems exist because of the financial constraints imposed on the VA, it is our responsibility, as elected representatives, to ensure that appropriation levels are sufficient to meet the needs of the VA health care system and those it was established to serve.

11. My written testimony will outline some of the broad concerns that have been brought to my attention. It will also highlight some of the most alarming stories veterans and their families have shared with me. I am certain that you will hear similar stories here today. Additionally, questions about how the consolidation plan, devised by Undersecretary Kizer, has severely limited Hudson Valley veterans access to full service health care will be explored. This plan seems destined to create a self fulfilling prophecy, cuts in funding, reduction in services followed by fewer veterans using the VA facilities, which results in additional funding cuts. I think the pattern becomes painfully obvious.

12. Castle Point and Montrose are integral parts of the health care system in the Hudson Valley. It is my hope that, working together, we can ensure their continued availability to veterans in this region.

B. **Specific cases detailing perceived problems**

1. **Frank A. Bove** (SS# 154-20-6627)

a. Frank A. Bove, a World War II veteran with a 35% service connected disability was admitted to Castle Point VA Nursing Home in September 1996.

b. His wife, Veronica Bove and his daughter Ann, contacted my office in early May 1997 with concerns about the poor quality of care he began receiving in February 1997. They were told that his move to another unit was a result of the restructuring plan.

c. After Mr. Bove was moved to another nursing home unit, it immediately became obvious that the care he was receiving was no longer consistent and that the nursing staff was markedly smaller. After only two days in this new unit, he fell out of his wheelchair and broke his left hip.

d. It was at this point that Ann Bove, a licensed nurse with many years of experience, began to have some very serious concerns about her

father's care. The Castle Point staff had taken x-rays and determined that Mr. Bove was not injured by his fall. However, two days later his wife and daughter were advised that he was being transferred to the Manhattan VA to undergo emergency surgery. Apparently, he was not fine and, in fact, had broken his hip.

e. Subsequent to his surgery, Mr. Bove began losing weight although the staff ensured the family he was eating. He was also suppose to receive rehabilitation therapy when his condition stabilized, but this was not follow-up on by the staff.

f. Another reason the Bove family questioned the care their loved one was receiving stems from Castle Point's failure to properly monitor his diabetic condition. At one point the Physician's Assistant who was working with him led the family to believe he had suffered a stroke when, in fact, he had been left un-monitored and his glucose level plummeted to a dangerously low level of 25mg/dl. This value, I am told constitutes a life threatening situation.

g. Ann Bove indicated that in the hospital in which she worked this was a safety violation and the hospital would be required to file a report with the Department of Health. She openly questioned who had oversight over safety and health conditions and well as standard continuity of care procedures at the VA facilities.

h. Mr. Bove has since passed away. His family is left with many questions about his treatment in the Castle Point facility. The wonder if his stay there served to hasten his death.

2. **William Vega, Jr.** (SS# 121-34-7007)

a. William Vega was admitted to Castle Point on April 12, 1997 after being diagnosed as having gallstones. He was 52 years old. On May 3, 1997 he passed away due to peritonitis.

b. According to the information provided my office, surgery was scheduled for Tuesday April 15th. The surgery started as a laparoscopic surgery and was converted to open surgery. His gall bladder was removed due to infection.

c. After being released from ICU to a regular unit, Mr. Vega had constant pain and long delays in receiving medication upon request. His wife was advised that his pain and shortness of breath were because he was not getting up and walking. She then convinced him to follow the doctor's instructions so that he could get home sooner.

d. After several days without improvement and with increased pain, he underwent some testing and a specialist from the Bronx was called in. It was determined that there was some type of leakage or a gallstone on the kidneys and that he should be transferred to the Bronx for further treatment.

e. While at the Bronx VA, Mr. Vega underwent two additional surgeries. The first surgery showed the extent of the damage and the second, which lasted 7 1/2 hours was to correct the problem. Apparently, the gall

duct was open and the bile was entering into his system. It had already affected his lungs, kidneys and intestines. The date was now April 24th.

f. As of May 1st there was still some concern about his lungs but the doctor was still very positive. On May 2nd, Mrs. Vega was advised that her husband had caught some type of infection and on May 3rd at 1:15 AM he passed away.

g. Mrs. Vega believes that the surgeons who performed the original surgery were not fully qualified. Further, that the staff at Castle Point did not take seriously Mr. Vegas complaints about pain and failed to recognize that his pain might be associated with symptoms of peritonitis.

h. I have enclosed a narrative from a Castle Point employee that outlines this case and the questions it raises about the facility and the doctors. This employee has chosen to remain anonymous.

3. **Clifford Mattison** (SS# 117-10-2853)

a. Mr. Mattison presented himself at the Castle Point emergency room on January 20, 1996 with symptoms of coughing and shortness of breath.

b. The ER doctor examined Mr. Mattison with a stethoscope, but no chest x-rays were taken. The physician, Dr. Serrano, sent him home, pronouncing his lungs clear. He also gave instructions to return on Monday to see his regular doctor.

c. Over the course of the next day his condition worsened and he became incoherent. On January 22nd, the paramedics were called and Mr. Mattison was transported to Ellenville Community Hospital. X-rays revealed that he had fluid in the lower 2/3 of both lungs. Later in the day he was transported to Castle Point, arriving in critical condition with both congestive heart and renal failure.

d. Although his condition stabilized over the next few days, when the treating physician was directed to remove a feeding tube, he condition relapsed. Mr. Mattison died on February 10th.

e. Mrs. Mattison and her daughter, Shirley Mangles, believe that the lack of proper treatment/diagnosis on January 20th ultimately resulted in Mr. Mattison's demise. Additionally, they are unsatisfied with the internal inquiry into their complaints conducted by VA staff. This stems, in part, from the fact that their reply indicated that Mr. Mattison presented himself in the ER for urinary incontinence, weakness and the inability to eat. Based on those symptoms, the VA found Dr. Serrano's treatment proper and that their facility had acted with all appropriate measures.

f. Ms. Mangles, with our assistance, obtained copies of medical records and x-rays. She presented these to an independent physician for review. I have enclosed a copy of this doctors review of those record. Clearly, he finds fault with the steps that Dr. Serrano took, or rather failed to take, on January 20th.

g. Mrs. Mattison and Ms. Mangels believe they have enough proof to

bring a negligence suit against the VA and obtain monetary compensation. At the very minimum they would like the VA to admit that Dr. Serrano's treatment/diagnosis did not adequately respond to the symptoms which he had. They would like to see him discharged from the VA.

4. **Harold Niver**

a. Mr. Niver was admitted to Castle Point on March 24, 1997 complaining of stomach pains and the sudden on-set of diarrhea. He was placed under the care of Dr. Chitti Chaisetseree.

b. He remained an inpatient at Castle Point for two weeks during which time his condition worsened. The family had a great deal of difficulty trying to communicate with the doctor, who never bothered to return phone calls. When they were finally able to speak with Dr. Chaisetseree, he told them that Mr. Niver had a virus.

c. Some of the points they raised about his care included the following: Mr. Niver had requested a bed pan and, after waiting for many hours, finally soiled the bed, on another occasion he was experiencing chest pains and the nurse told the family that it was only angina or a panic attack and gave him nitroglycerin, the family had to point out that he was retaining fluids before they decided to put a catheter in place, he lost his appetite, was dehydrated yet still retaining fluids.

d. On April 7th, Cindy Trimble (his granddaughter) contacted Dr. David Burns at the Hudson Valley Hospital in Peekskill and made the initial arrangements to have Mr. Nivers transferred. Dr. Chaisetseree was annoyed and, although uncertain as to what was wrong with Mr. Niver's, would not authorize his discharge.

e. Dr. Chaisetseree telephoned Dr. Burns, indicating that he did not know what was wrong with Mr. Niver's, and that he had not been able to get a stool sample to do further testing. Dr. Burns immediately recommended a procedure that would allow him to get the sample he required, however, Dr. Chaisetseree wanted to wait another 48 hours. The family wanted to move forward with the transfer. Dr. Chaisetseree refused to allow Mr. Niver to be discharged, although the ambulance service was there to transport him to Hudson Valley Hospital.

f. The family finally made contact with a Dr. Patel, Acting Chief of Staff for April 8th, and he authorized the discharge. Within an hour of arriving at Hudson Valley Hospital, Dr. Burns discovered a perforated ulcer and indications of a recent heart attack. There was acid and bacteria found in his blood, causing an infection. He was taken in for surgery at 11:30 P.M., but subsequently died of septic shock from the pre-existing infection caused by the perforated ulcer.

5. **John Quinn** (*SS#* 081-20-1705)

a. Contacted the office with allegations of abuse while an inpatient at Castle Point. He alleges that on December 26, 1996, while a patient in Ward B-1, the night nurse, who he identifies as Mei, withheld prescribed pain medication, taunting him by holding it just out of his reach.

He also alleges that she physically assaulted him, pounding on his shoulders and chest and taking direct finger stabs at his porto-o-cath. He also stated that she hit him in the head as he tried to allude him, sending his glasses flying. It should be noted that Mr. Quinn is confined to a wheel chair

b. The following morning he was abruptly discharged. He contacted our office and we wrote to Castle Point. According to their response, they are familiar with many of the patient care related concerns which he expressed and they are having their Performance Improvement Team look into the matter. This was as of June 26th and, to date, no further information has been released.

6. **Edward VanLeer** (SS# 136-48-9699)

a. Contacted the office with numerous complaints about the quality of the care at Castle Point, the Bronx and Albany. His allegations range from inadequate diagnosis, to refusal of treatment.

7. James F. Catania

a. Contacted our office to express his dissatisfaction with the VA system. Claims that he was shuffled back and forth between Castle Point and the Bronx in his effort to secure a hearing aid. He was told to go to the Bronx because they had better equipment to conduct an extensive examination. After waiting almost 4 hours to be seen, he was told they were sending him back to Castle Point for the same reasons he was sent to the Bronx.

8. **Ralph Basso**

a. Presented himself at the Castle Point emergency room with upper respiratory symptoms. Test were taken and he was sent home, although he was in obvious distress. Several hours later he was phoned at home and told to return to the hospital to be admitted as he was suffering from pneumonia.

C. **Miscellaneous Complaints**

1. The office has received numerous other calls concerning all aspects of VA health care. Those complaints include some of the following issues.

a. Reduction in dental staff and services, resulting in extensive wait times for treatment.

b. Extensive wait times at the pharmacy facility at Castle Point. Allegations that assistants are doing the job of the Pharmacist and that there have been errors as a result.

c. Unsanitary conditions in patients rooms, soiled bathrooms go many hours without cleaning, floors are "cleaned" with dirty mop water.

d. Complaints that nursing staff (including RN's, LPN's and CNA's) are inattentive, and not able to address all patients medical, nutritional and hygienic needs. The general sense is that reduction in staffing, which has caused them to be overworked, is complicated because they are trying to carry the weight of under qualified physicians.

e. Complaints that the physicians affiliated with the facilities are barely able to speak English, causing communication problems with both the nursing staff and the patients and their families. The qualification of certain doctor's has been called into question, how are they rated as specialists in any particular field, what is their educational background, what is their experience level when hired by the VA.

f. Concern about the decline in services at the Castle Point facility. Although we have received word that their emergency room will remain as a Level 3 ER, veterans have expressed concern about the treatment they will be able to obtain if they present themselves in an emergency situation. Veterans are also concerned about the distances they must travel to receive inpatient care. They question the long term effect on injury/illness if scheduling and/or transportation problems further

52 year old veteran WV.

Admitted to Castle Point (D-1) on 4/12/97 for Cholecystectomy (Gall Bladder surgery).
Attending physician: Dr. Chaisetseree
Surgeons: Dr. Chu-Aquino and Dr. Barry (resident)
Patient developed complications and transferred to Bronx VA.
Patient expired on 5/3/97 due to peritonitis.

- Procedure started as laparoscopic surgery and converted to open surgery. (Why?)
- Reportedly, patient was not properly cut off and tied, bile went into stomach, and patient needed intubation. (Why?)
- Reportedly, there was no anesthesiologist on call at Bronx VA (Why?)
- Transfer time to Bronx is a minimum of 45 minutes, why were they not ready?
- Was an autopsy performed on this patient?
- Was patient transferred by an ACLS ambulance?
- If patient had a hot stomach, why was he not transferred to a local hospital?

Laparoscopic surgery is a highly specialized procedure requiring formalized training, significant hands-on experience, and demonstrated competence.

- What is the criteria at Castle Point VAMC for granting privileges in laparoscopic cholecystectomies?
- Are surgical residents privileged to perform laparoscopic surgery? With a highly skilled proctor?
- How long has Dr. Chu-Aquino held privileges in laparoscopic surgery at Castle Point?
- Reportedly, Dr. Chu-Aquino has had minimal training in this procedure from a Castle Point Consultant. In this regard, what indicators are used to evaluate the quality of care rendered by Dr. Chu-Aquino in performing this new procedure, for example:
    1. How many laparoscopies has Dr. Chu-Aquino performed in the past year?
    2. What were the results of these procedures?
    3. Morbidity and mortality data available?
    4. Patient survey data available?
- Considering the size of this facility and the relatively infrequency of performing this new technology, has Dr. Chu-Aquino completed any further continuing medical education in this new procedure?
- Since there is no longer a full time Chief of Surgical Service at this facility:
    a) What monitoring mechanism and review process has been established to assure that surgical practitioners and surgical residents provide services within the scope of their privileges?
    b) What are the qualifications of the individuals being placed in supervisory positions in Surgical Service?
    c) Do they have surgical training?

d) Can they scrub?

Other issues of great concern at Castle Point VAMC:

- The increased number of moralities:

  There has been a notable increase in the number of deaths at this facility in the past year (Why?)

- The increased number of Tort Claims and Boards of Investigations:

  Reportedly, the number of Tort Claims and Boards of Investigations has increased dramatically. The facility averaged 3 to 4 claims annually, and now the average has increased to 3 to 4 claims monthly. (Why?)

- The decline in the standard of care:

  - The administration at the facility, both clinical and non-clinical, have an obligation to assure that the quality of patient care provided within all services is monitored and evaluated.
  - It has become blatantly apparent that the standard of care at this facility has declined. (Why?)
  - Will this facility pass the Joint Commission review for accreditation scheduled in October?

October 15, 1996

Edgar Campbell
2 Madison Avenue
Valhalla, New York 10595

Re: Clifford Mattison

Dear Mr. Campbell:

I have read the medical records recently forwarded me having particularly to do with the above captioned person's visit to the Castle Point VA Hospital emergency room on January 20, 1996 and the subsequent events at the Ellenville Community Hospital on January 22, 1996 and subsequently again at the Castle Point VA Hospital extending until the time of his demise. On the basis of these data it is my opinion that the emergency room record from the Castle Point VA Hospital generated by a physician on call in the emergency room whose name is illegible to me represents a disgrace to the medical professional and certainly to the Veterans Administration.

Among other things, this record under the triage section does not truly, fully and accurately relate the patient's problem and complaints. Complaints at this time were particularly shortness of breath, wheezing and swelling of the feet and ankles. These problems are not indicated on this medical record. The section for history and physical is unbelievably below standard in essentially all respects. The entry shows the presence of occasional ronchi and rales and no wheezes which is contrary to the history. There is no comment regarding the condition of the veins in his neck, his color, his general condition, the presence or absence of pulmonary findings on percussion such as dullness and/or decreased breath sounds in the bases. Under abdomen there appears to be a simple negative regarding organomegoly or other problems and under extremities the entry of no pedal edema which is contrary to the obvious fact that he did have edema according to his wife who of course is only a layperson. This history and physical is such as to not contribute to the formulation of anything like a reasonably accurate diagnosis and indeed in this case no such diagnosis was made. The physician entered as diagnosis viral syndrome with nothing whatsoever to support this and he also noted an increased in the person's PT time which in my opinion had nothing to do with his presenting problem. On the basis of these information errors the doctor advised that the patient's heart and lungs were okay and that there was an abnormality in his PT time which should be corrected and he was summarily discharged to his home with

instructions to reduce his Coumadin and to return to the clinic in a few days.

At home his condition continued to deteriorate with increasing difficulty in breathing until his wife took him to the emergency room of Ellenville Community Hospital on the morning of January 22, 1996. At this time the attending physician properly and easily made the diagnosis of pulmonary edema, ruled out pneumonia, acute myocardial infarction, rule out recent as well as past health problems including an old CVA, auricular fibrillation insulin dependent diabetes and hyperthyroidism. It was appropriately treated at this institution with ventilatory support, diuretics, serial EKG's and enzymes. His enzymes were abnormal, his blood gasses were materially decreased. Because of local mechanical problems in this hospital he was transferred later the same day to the Castle Point where he arrived in very serious condition. It evolves that he most probably had suffered another myocardial infarction and it appears that his pulmonary edema had progressed to bilateral pneumonia, these two things of course placing him in life threatening jeopardy and he indeed did die from these problems.

It is my opinion that the two day hiatus with no treatment materially adversely affected his cardiopulmonary situation to the extent that the myocardial infarction was precipitated by his hypotension, hypoxia, dyspnea, etc. and that the pneumonia likewise was a direct and proximate result of the untreated pulmonary problem over these two days. Therefore this hiatus of no treatment in my opinion was the proximate cause of his demise.

Mr. SHAYS. This committee is holding this field hearing, again, at the request of Mr. Gilman and Mr. Hinchey as well as Sue Kelly. And, Ms. Kelly, you have the floor.

STATEMENT OF HON. SUE KELLY, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF NEW YORK

Ms. KELLY OF NEW YORK. Thank you very much, Chairman Shays. I want to thank you for holding this hearing and for respecting the veterans in this area who use Castle Point and Montrose facilities enough to come up here to the district and listen to what they have to say to the Veterans Administration.

I think this is an important hearing. I especially appreciate the opportunity in light of the recent reports that we've had of diminished quality care at both Castle Point and Montrose. I can't think of a more important issue for veterans nationwide than ensuring the Federal Government maintains its commitment to provide high-quality health care to them and for their service for our Nation.

The question here is really: Is the present veterans' equitable resource allocation, VERA, model and the manner in which it has been implemented good for the Hudson Valley veterans or just those in select areas of the Nation?

I can tell you now, Mr. Chairman, that I have very grave concerns that today's VERA model shirks this Nation's commitments to New York's veterans. In this area of the country, in our network, we're taking the largest cut of any other network in the Nation, a 15 percent cut in overall veterans' health care funding, which translates into a nearly $150 million cut. Yet, we have the highest number of veterans who need special care and the fourth highest number of veterans who need medical care.

It's the laudable goal of the VA to ensure that veterans receive the same high-quality care Nationwide at any medical care facility, but I believe all here would applaud this goal. However, the problems begin with the VA's implementation of robbing Peter to pay Paul, taking from one network to give to another.

The logic behind these actions appears to be flawed in several respects. First, the funds are being reduced in our network. And they are not being taken because of a lack of need in one area but for a seemingly greater need in another.

Also, we can't possibly take into consideration all of the reasons that one area historically receives greater funding due to factors that are difficult to measure, such as regional differences in cost of living, wage scale, as well as the presence of older and sicker patients.

In the General Accounting Office's May 1, 1997, report on the VA health care assessment of VA's fiscal year 1998 budget proposal, the GAO notes a number of similar warnings about the implementation of VERA, including VERA may shift some resources inappropriately because it may not fully account for justifiable differences in regional cost variations. The VA may not have taken into account, for example, that veterans are sicker and need more health care services in different parts of the country so that additional case mix adjustments may be necessary to fully explain regional cost differences. And VERA's incentives for lower cost per veteran

and higher workload numbers could lead to unintended consequences.

A second flaw that I find is that if the VA has been instituting broad-based eligibility reform proposal, which is supposed to expand the number of veterans that each network will serve while at the same time implementing the VERA plan, how can the VA even begin to accurately calculate the number of eligible veterans requiring care in the present system or even forecast future enrollment numbers? Further, how can the VA accurately track the real-world impact of the reforms while they're shifting money from network to network? Shouldn't they wait until they know what the numbers are?

Additionally, and more to the point, my greatest concern is that these reforms will result in a reduction in the quality and accessibility to health care that veterans deserve and depend on.

As we speak, the VA's medical inspector's office is finalizing its in-depth examination of conditions at Castle Point and Montrose, but the results won't be available for at least 2 to 3 months.

Additionally, while we are trying to get to the bottom of these reports, we have the network leadership making blanket statements about their ability to deliver quality care without waiting on the medical inspector's reports or even the final Joint Commission on the Accreditation of Hospitals' report.

The VA has a credibility gap, to say the very least. And to fault these types of correspondence against the present backdrop does nothing to restore the full faith and confidence of our veterans in their VA system.

It's because of these latest actions on the VA's part that I'm looking forward to an impartial, unbiased audit of our network by the GAO whereby they will be reviewing the human impact of the VERA model on the VA's ability to deliver quality health care in New York. This is the language which I and many of my colleagues here work to secure in the fiscal year 1998 VA/HUD appropriations.

Our veterans, like all citizens, deserve answers from their government that are clear and truthful. And I'm sorely afraid that we have not yet reached this point. Hopefully this GAO study will shed some much needed light on some of the unintended consequences of VERA's implementation.

So while we have no idea what the GAO may or may not conclude in their reports, I have faith that they will conduct at least a fair and honest accounting of the situation, just as they have in their past reviews of the VA and the VERA program.

Finally, Mr. Chairman, I'd like to close by quoting the same May 1997 report I cited earlier, which concluded that delaying a decision on VA's legislative proposals until critical information is available, including a plan describing how the system will look and operate in 2002, may result in a better legislative decision on the VA's budget proposal. It will also afford the VA and the Congress better time to assess how VA's future resource needs may be affected by the new decentralized management and resource allocation initiatives.

This is a very important point. It is this very delay I've been pressing for over these past 9 months. I will continue working for

high-quality medical care that is immediate and accessible for all of our veterans until we get all of the answers.

I look forward to the testimony of our witnesses. And thank you, Mr. Chairman, for allowing me to take part in the proceedings. [Applause.]

[The prepared statement of Hon. Sue Kelly follows:]

Statement of Congresswoman Sue Kelly (NY-19)
Government Reform and Oversight Subcommittee on Health Hearing on "Restructuring VA Medical Services: Measuring & Maintaining the Quality Care"

Monday, August 4, 1997
Wallkill Community Center in Middletown, NY

Chairman Shays, I want to thank you for holding this important hearing on our nation's changing VA health care system, and I, like my constituents, especially appreciate this opportunity in light of the recent reports of diminished quality care at both the Castle Point and FDR Montrose Veterans Medical Facilities. I cannot think of a more important issue for veterans nationwide than ensuring that the Federal government maintains its commitment to provide high quality health care to them for their service to our nation. The question is "Is the present Veterans Equitable Resource Allocation (VERA) model and the manner in which it has been implemented good for Hudson Valley veterans or just those in select areas of the nation?" I can tell you now, Mr. Chairman,

that I have very grave concerns that today's VERA model shirks our commitment to New York s veterans. In this area of the country, in our Network, we are taking the largest cut of any other Network in the nation -- a 15% cut in overall veterans health care funding which translates into a nearly $150 million, yet we have the highest number of veterans who need special care and the fourth highest number of veterans who need medical care.

It is the laudable goal of the VA to ensure that veterans receive the same high quality care nationwide at any VA medical care facility, and I believe all here would applaud this goal. The problems begin in the VA s implementation of this goal when we "rob from Peter to pay Paul," taking from one Network to give to another. The logic behind these actions appears to be flawed in several respects.

First, the funds being reduced in our Network are not being taken because of a lack of need in one area, but for

a seemingly greater need in another area. Also, we cannot possibly take into consideration all of the reasons that one area historically receives greater funding due to factors that are difficult to measure, such as regional differences in cost-of-living, wage scale, as well as the presence of older and sicker patients.

In the General Accounting Office's May 1, 1997 report on VA Health Care -- Assessment of VA s Fiscal Year 1998 Budget Proposal, the GAO notes a number of similar warnings about the implementation of VERA, including:

1) VERA may shift some resources inappropriately because it may not fully account for justifiable differences in regional cost variations;

2) The VA may not have taken into account, for example, that veterans are sicker and need more health care services in different parts of the country, so that additional case mix adjustments may be necessary to

fully explain regional cost differences; and

3) VERA's incentives for lower costs per veteran and higher workload numbers could lead to unintended consequences.

The second flaw I find is that if the VA has been instituting a broad based eligibility reform proposal which is supposed to expand the number of veterans that each Network will serve, while at the same time implementing the VERA plan, how can the VA even begin to accurately calculate the number of eligible veterans requiring care in the present system or even forecast future enrollment numbers? Or further, how can the VA accurately track the real world impact of these reforms while shifting monies from Network to Network? Shouldn't the VA wait until they know what these numbers are?

Additionally, and more to the point, my greatest

concern is that these reforms will result in a reduction in the quality and accessibility to health care that veterans deserve and depend on.

As we speak, the VA's Medical Inspector's office is finalizing its in-depth examination of the conditions at the Castle Point and Montrose VA Medical Centers, but the results will not be available for at least two to three months. Additionally, while we are trying to get to the bottom of these reports, we have the Network leadership making blanket statements of their ability to deliver care, without waiting on the Medical Inspector's reports or even the final Joint Commission on the Accreditation of Hospitals report. The VA has a credibility gap to say the very least, and to float these types of correspondence against the present backdrop does nothing to restore the full faith and confidence of our area's veterans in their VA health care system.

It is because of these latest actions on the VA's part that I am looking forward to an impartial and unbiased

audit of our Network by the GAO, whereby they will be reviewing the human impact of the VERA model on the VA's ability to deliver health care in New York. This is the language, which I and many of my colleagues here worked to secure in the FY 98' VA-HUD Appropriations. Our veterans, like all citizens, deserve answers from their government that are clear and truthful, and I am sorely afraid that we have not yet reached this point.

Hopefully, this GAO study will shed some much-needed light on some of the unintended consequences of VERA's implementation. So while we have no idea what the GAO may or may not conclude in their reports, I have faith that they will conduct a fair and honest accounting of the situation, just as they have in their past reviews of the VA and the VERA program.

Finally, Mr. Chairman, I would like to close by quoting the same May 1997 report that I cited earlier, which concluded that "Delaying a decision on VA's legislative proposals until critical information is available -- including a plan describing how the system will look and operate in 2002 -- may result in a better legislative decision on VA's budget proposal. It will also afford VA and the Congress time to better assess how VA's future resource needs may be affected by the new decentralized management and resource allocation initiatives." It is this very "delay" that I have been pressing for over these past nine months, and will continue working for until we get all the answers.

I look forward to the testimony of our witnesses, and again, I thank you, Mr. Chairman, for allowing me to take part in these proceedings.

Mr. SHAYS. I want to thank all of you because I know a number of you are standing. Let me just say that for some of you who are sitting, maybe in an hour or so you will be able to relinquish your chair to someone who is standing.

This hearing will probably go on beyond 5 o'clock today. Let me just state how we are going to proceed. We have two panels that will be addressing this subcommittee. We will be asking them questions. And the third panel will be people from the audience, who will be invited at random to address us and make the points that you would like to make. I will tell you as the chairman of this committee I will stay here quite a long time to make sure that we hear from as many people as possible.

We are transcribing this hearing. We have an official record of this hearing. And I want to say to all of you the purpose of this hearing is to make change. We want to learn as much as we can learn.

And I just need to get one housekeeping part taken care of and, ask unanimous consent that all members of the subcommittee be permitted to place any opening statement in the record and the record remain open for 3 days for that purpose. And, without objection, so ordered.

And I ask further unanimous consent that all witnesses be permitted to include their written statements in the record. And, without objection, so ordered. And I will invite anyone from the audience as well to submit a written statement, and it will be part of the record and will be reviewed.

[The prepared statement of Hon. Alphonse D'Amato and public submissions follow:]

TESTIMONY
by
U.S. SENATOR AL D'AMATO
before
HOUSE COMMITTEE ON GOVERNMENT REFORM & OVERSIGHT
HUMAN RESOURCES SUBCOMMITTEE
August 4, 1997

Mr. Chairman, I want to thank you and Congresswoman Kelly for holding this important hearing on an issue of grave concern to New York's veterans. The almost two million men and women in our state who have served in our country's armed forces deserve the best health care we can possibly provide. Sadly, they are not getting it.

In fact, as you well know, the health care being provided at Montrose and Castlepoint, the two facilities this hearing is focused on today, is extremely poor. There have been well publicized reports that due to their ongoing merger under the VERA system, mortality rates have skyrocketed by 80% at Montrose and 100% at Castlepoint in just a six month period. And that is just the tip of the iceberg.

Extremely poor health care and neglectful sanitary conditions have also been reported at both facilities including misdiagnosed infections and heart attacks, moldy suction tubes, patients lying for hours at a time in their own waste, and, in one report, a man actually dying for lack of a doctor as physicians conduct a meeting without their beepers. If even half of these reports are accurate, it is an outrage. If they are all true, it is a shameful tragedy.

We must learn the truth about these terrible reports of cruelty, and in some cases, even death. We must be sure that the massive restructuring of the Veteran's health care system and the associated reallocation of resources is done not just fairly but safely. If these reports are true, then there is absolutely nothing fair and equitable about VERA, the so-called Veteran's Equitable Resource Allocation System. So, I say again, we must learn the truth.

That is why I recently offered an amendment to require the General Accounting Office (GAO) to get the facts. Specifically, my amendment directs the GAO to conduct a study examining the factors relied upon by the VERA and Veterans Integrated Service Network (VISN) systems to distribute health care funds. The study will focus on the

high number of special needs veterans residing in Northeastern States, the impact of eligibility reform on veterans, and the quality and accessibility of health care in the Northeast region. My amendment also directs the VA to fund all VISNs at their fiscal year 1996 levels until the GAO study is received by the VA/HUD Appropriations Subcommittee.

It is absolutely crucial for our New York veterans that all of those factors be considered by the VA as the VERA system continues to be implemented. More importantly, it is imperative -- in some cases a life or death situation -- that the results of the GAO assessments be incorporated as soon as possible into the VERA system.

Currently, my amendment was included in the Senate VA/HUD Appropriations Subcommittee bill. It is awaiting Congressional conference committee action with Congresswoman Kelly's House provisions. During conference in early September, Congresswoman Kelly and I expect to secure a freeze on implementation of the fiscal year 1998 VA health care funding for New York State until the results of the study can be incorporated into the VERA system. With this study, we will ensure that America's veterans receive a fair reckoning as the VERA system is imposed upon them.

It is my sincere hope that this hearing you are holding today will help focus critically needed attention on the suffering that our veterans are enduring at the hands of a system that supposedly exists to serve their health care needs.

THE FOLLOWING WRITTEN STATEMENTS HAVE BEEN MADE PART OF THE HEARING RECORD AND CAN BE FOUND IN SUBCOMMITTEE FILES

"This Is A Call To Action!!!" literature, with petition attached

Catherine A. Waugh of Washingtonville, NY

Ray E. Parris of Washingtonville, NY

Stephen F. Kistner of Circleville, NY

Vincent DeMarr, Program Administrator, Westchester County Veterans Service Agency

John L. Cornell of Highland Mills, NY

Leonard J. Stavish of New City, NY

Maria Montalvo

Iris Pettiford Cox, Organizer, Veterans, Relatives and Friends Committee of Southeast Queens

Nancy Smith

Anne Samoylo of Cortlandt Manor, NY

Mary Ellen Ginnetti of Redding, CT

Michael F. Cragan of Walden, NY

Marie Graziosi of Marlboro, NY

Veronica Bove' of Marlboro, NY

Daniel J. Reilly

William M. Bloom, Sr. of Cornwall, NY

Ralph U. De Marco, National Council Member and New York State Legislative Chairman of Veterans of Foreign Wars, and President of the New York State Council of Veterans Organizations

Ralph J. Karabec of Monroe, NY

Patricia A. Hulse of Sparrowbush, NY

Robert La of Newburgh, NY

Anonymous

Sergio A. Morales of Newburgh, NY

Anthony J. Buccieri of Newburgh, NY

Enrico Messina, LPN

Robert L. Cahill, Commander, American Ex-Prisoners of War, Hudson Valley Chapter

Sandra Schwartz of Poughkeepsie, NY, Life Member, Disabled American Veterans Auxiliary

Barney Barlam of Spring Valley, NY

Fran Cocuzza of Hopewell Junction, NY

Betty De Marco, State of New York Legislative Chairman, Ladies Auxiliary to the Veterans of Foreign Wars of the United States

Philip Duro and Debby Szeredy-Duro of Fishkill, NY

Lowell T. and Patricia A. Hulse of Sparrowbush, NY

Francis Curtis of Yorktown Heights, NY

Eileen Yonnene of New Windsor, NY

Patrick Hough

William I. Perez

William B. Stedman of Hyde Park, NY

Larry Byrne of New Windsor, NY

Alice McMann of New Windsor, NY

Ray Gordon

Mr. SHAYS. We will not be taking questions from the audience, but at this time we will be inviting our witnesses. Our first witness, Mr. James Farsetta, who is the Director of Veterans Integrated Service Network 3; accompanied by——

[Chorus of boos.]

Mr. SHAYS. May I make a request? I have to have enough faith in all of you here that you will recognize that the purpose of this hearing is to get the truth. I can welcome applause. I can welcome applause for issues you agree. But I can just say to you from the bottom of my heart we cannot have you be rude to people. That is the one request I make. And I make a request that you respect the work of this committee for being here and that we will learn and make the changes necessary.

And, as a Member of Congress, I do not place all the blame in one direction. Congress has to take some of the blame. The administration has to take some of the blame as well.

We will get to the truth. We will get to the truth. And at this time, Mr. James Farsetta, who is the Director of Veterans Integrated Service Network 3; accompanied by Ms. Maryanne Musumeci, who is the Director of the Bronx VA Medical Center; accompanied by Mr. Mike Sabo, Director, Hudson Valley VA Health Care System. We will also be hearing testimony from Dr. Nancy J. Wilson, Director, VA Office of Performance Management.

As is the practice of this committee, we swear in all our witnesses who will be testifying, even Members of Congress when they testify. And I would invite all of you to stand up and raise your right hand, please.

Do you solemnly swear or affirm that the testimony you will give before the subcommittee will be the truth, the whole truth, and nothing but the truth?

Mr. FARSETTA. I do.

Ms. WILSON. I do.

Mr. SABO. I do.

Ms. MUSUMECI. I do.

Mr. SHAYS. For the record, all four have stated in the affirmative. Mr. Farsetta, it's very nice to have you here today, sir. Thank you very much. You may begin.

Mr. FARSETTA. Thank you.

STATEMENTS OF JAMES FARSETTA, DIRECTOR, VETERANS INTEGRATED SERVICE NETWORK 3, ACCOMPANIED BY MARYANNE MUSUMECI, DIRECTOR, BRONX VA MEDICAL CENTER; MICHAEL A. SABO; DIRECTOR, HUDSON VALLEY VA HEALTH CARE SYSTEM; AND DR. NANCY J. WILSON, DIRECTOR, VA OFFICE OF PERFORMANCE MANAGEMENT

Mr. FARSETTA. Mr. Chairman, Congresswoman Kelly, Congressman Gilman, Congressman Hinchey, veterans, family members, community leaders, community individuals, thank you for the opportunity to appear before the subcommittee and provide information regarding the restructuring of services and the quality of care at the Castle Point and Montrose VA Medical Centers.

As you know, in recent years VA had been receiving mounting criticism from Congress, General Accounting Office, private health care systems, and veterans about being a bureaucracy that cared

for too few veterans with too many hospitals and too many beds. In acknowledgment of these varied concerns, the VA health care nearly 2 years ago adopted a new vision for how veterans' health care would be delivered.

Dr. Kizer, the Under Secretary of Health, published his "VISION for CHANGE." In that document, which was shared with Congress and other stakeholders, he outlined a plan to streamline the bureaucracy, reduce excess staffing, close unused beds, improve patient satisfaction, and shift resources to take care of more veterans on an outpatient basis closer to their homes. A new network structure of 22 Veterans Integrated Service Networks, VISNs, was set up to ensure quality care and improve efficiency. During the past 2 years, VHA has undergone tremendous change throughout the entire system, including New York.

The private sector health care community has called this change innovative and remarkable and has said, "It is about time." In the New York/New Jersey VISN, we have been doing many things that our colleagues have been doing across the country. We have carefully monitored the pace of change to ensure that care has not been affected. Many of our overall care indicators with respect to quality have actually improved. In addition, patient satisfaction across the network has also improved according to recent surveys.

The VA serves a patient population that is older, more burdened with disease, and has more problems overall than those seen by other health care providers. Please understand that these risk factors would not excuse even a single occurrence of flawed care, but mistakes occur in every system in which people are involved in something as difficult as health care.

However, with these allegations of poor care, we take them very seriously. When those indicators come from within our own monitoring system or come from the veterans themselves, we do what it takes not only to make things right but to ensure that the situation doesn't happen again.

We have carefully reviewed each case that has been brought to our attention during the past few months either by the media, our elected representatives, veterans, or veterans' family members. It troubles me deeply about the stories of poor care. And if I didn't say it before and if we didn't say it earlier, I want to offer my personal apologies to any veterans and their families for care that we did not provide that we should have provided.

We can all understand the pain of a family member whose sole purpose is the compassionate care and treatment of their loved ones. Our veterans have earned this care because they gave so much of their service to this country. And the only reason that we are here today is because of that service.

For those cases that have been spotlighted, I want every patient and family member to know that we are working to ensure that their concerns are fully addressed and that any failures that may have occurred never happen again. This is my first priority and, therefore, the priority of each and every staff member at Castle Point and Montrose and in the rest of the network.

For highlighting many of these incidents, I want to thank our congressional representatives and our service organization leaders for their undying concern and efforts on behalf of our veterans.

We do acknowledge that there are some longstanding issues that are cause for concern I am not completely satisfied with the overall physical plant and cleanliness of the environment. There are problems with waiting times to see care-givers, waits to get appointments, and waits at our pharmacies. Our standard expectations for basic customer services are not being met as often as they should be. There are also issues with staff-to-patient communication and staff-to-family communication that also exist. These problems are either being addressed or have been addressed. And I won't be satisfied until our patients and family members tell us that they are satisfied.

As I have said before, I will never tell you that every veteran who enters our hospitals or clinics gets perfect care. I can't say that because we could never achieve 100 percent perfection. I will tell you, however, that Castle Point and Montrose VA Medical Centers and Nursing Homes took care of over 16,000 veterans during the past year. And the vast majority of those patients are pleased with the care that we provide.

Our monitors, both internal and external, as well as discussion with veterans and their families indicate that the care provided in the VA Hudson Valley Health Care System is quality health care. However, to provide us with even greater assurance, I have asked the two medical centers to contact a large sample of families of our inpatients to see if the allegations of systematic substandard care were true or perceived to be true.

I am happy to report that the overwhelming majority of families, patients who were contacted are very satisfied with the care that they received. However, there clearly is a problem as evinced by the people in this room today. And I and my staff are here to listen to their concerns.

As for the VA medical inspector's visit, we anxiously await, as do the congressional representatives, the results of the team's review of the care provided to our veterans. I initially requested the review by the Office of Medical Inspector and have ensured that the Hudson Valley Medical Centers provide full cooperation in this important analysis. I can tell you that we are not waiting for the final report to make changes to further ensure the quality health care of our veterans.

Mr. Mike Sabo, who is the new permanent Director of the VA Hudson Valley Health Care System, has experience in operating a large two-division hospital. He brought that experience to the Hudson Valley and followed up with his excellent work at the Brooklyn VA Medical Center.

This was also followed by the excellent work done by Ms. Maryanne Musumeci, who was at Montrose-Castle Point for the past 3 years attempting to deal with a number of issues that have been raised in the media and raised by our congressional representatives.

Finally, in addition to serving over 3,500 brand new veteran users, we have also improved access and services to veterans in the entire Hudson Valley region. We have opened a new outpatient clinic in Rockland County and have just received approval for a clinic in Yonkers. We have also expanded services in White Plains, and have clinics currently in process for Kingston and Monticello.

It is truly my desire to open a number of new clinics in all corners of the Hudson Valley to better serve our veteran patients. Veterans who use these clinics are overwhelmingly satisfied with the services that are provided. A new mobile health van is also operating exclusively in the Hudson Valley to reach out to areas that have been under-served by the VA and to pockets of veterans in socio-economically disadvantaged areas, as well as direct outreach to homeless veterans in our more urban localities.

I want to thank you for the opportunity to share my thoughts with you today. Please be rest assured that our first priority is compassionate, high-quality care for our Nation's veterans. Anything less than that is unacceptable to me and the dedicated employees of the VA health care system.

I will gladly attempt to answer any questions that any of you may have.

[The prepared statement of Mr. Farsetta follows:]

Statement of VA NY/NJ Network Director

James J. Farsetta, FACHE

before the U.S. House of Representatives

Subcommittee on Human Resources

Committee on Government Reform and Oversight

August 4, 1997

Middletown, New York

Mr. Chairman, thank you for the opportunity to appear before the subcommittee and provide information regarding the restructuring of services and the quality of care at the Castle Point and Montrose VA Medical Centers.

As you know, in recent years VA had been receiving mounting criticism from Congress, GAO, private health care systems and veterans about being a bureaucracy that cared for too few veterans, with too many hospitals and too many empty beds. In acknowledgment of these varied concerns the Veterans Health Administration nearly two years ago adopted a new vision for how veterans health care would be delivered.

Dr. Kizer, the Under Secretary for Health, published his "VISION for CHANGE." In that document, which was shared with Congress and other stakeholders, he outlined a plan to streamline the bureaucracy, reduce excess staffing, close unused beds, improve patient satisfaction, and shift resources to take care of more veterans on an outpatient basis, closer to their homes. A new network structure of 22 Veterans Integrated Service Networks (VISN) was set up to ensure quality care and improve efficiency. During the past two years VHA has undergone tremendous change throughout the entire system including New York.

The private sector health care community has called this change innovative and remarkable and has said, "it is about time." In the NY/NJ VISN 3 we have been doing many of the same things as our colleagues around the nation. We have carefully monitored the pace of change to ensure that care has not been affected. Many of our overall care indicators, with respect to quality, have actually improved. In addition patient satisfaction across the network has also improved according to recent surveys.

The VA serves a patient population that is older, more burdened with disease and has more problems overall than those seen by other healthcare providers. Please understand that these risk factors would not excuse even a single occurrence of flawed care, but

mistakes occur in any system in which people are involved in something as difficult as healthcare.

However when there are allegations of poor care we take them very seriously. Whether those indicators come from within our own monitoring systems or come from the veterans themselves, we do what it takes to not only make things right but to ensure the same situation never happens again.

We have carefully reviewed each case that has been brought to our attention during these past few months, either by the media, our elected representatives or veterans. It breaks my heart to hear any stories of poor care. I want you to know that I offer my personal apologies to any veteran, and their family, who has not received the best care this nation has to offer. We can all understand the pain of a family member whose sole purpose is the compassionate care and treatment of their loved one. Our veterans have earned the best because they gave us their best in service to the country.

For those cases that have been spotlighted I want every patient and family member to know that we are working to ensure that their concerns are fully addressed and that any failures that may have occurred never happen again. This is my first priority and therefore the first priority of each and every staff member at Castle Point and Montrose. For highlighting many of these incidents, I want to thank our Congressional Representatives and our veteran service organization leaders for their undying concern and efforts on behalf of our area veterans.

We do acknowledge that these facilities have some long standing issues that we are working to overcome. I have not been completely satisfied with the overall physical plant and cleanliness of the environment. There are problems with waiting times to see care givers, waits to get appointments and waits at the pharmacy. Our standard expectations for basic customer service are not being met as often as they should be. There are also issues with staff to patient communications and staff to family communications that have existed. These problems either have been addressed or are in the process of being addressed and I won't be satisfied with these actions until our patients and patients' families tell us that they are satisfied.

As I have said before I would never tell you that every veteran who enters our hospitals or clinics gets perfect care, I couldn't say that, because it can never be 100% true. I will tell you, however, that the Castle Point and Montrose VA Medical Centers and Nursing Homes took care of over 16,000 veterans during this past year and the vast majority of those patients are pleased with the quality of care they received.

Our monitors, both internal and external, as well as discussions with veterans and their families indicate that the care provided in the VA Hudson Valley Health Care System is of high quality. However, to provide us with even greater assurance I asked the two medical centers to contact a large sample of the families of our inpatients to see if the allegations of systemic substandard care were true or perceived to be true. I am happy to

report that the overwhelming majority of our patients' families, who were contacted, were not only satisfied with the care provided by the VA, but complimented us on the compassion of our staff and the quality of our clinical interventions.

Let me address the recent allegations that budget reductions have resulted in an increased mortality rate at the Hudson Valley facilities. This is simply not true. We have done an extensive review of mortality at both medical centers. The analysis of the number and rate of deaths over the past three fiscal years demonstrates considerable month-to-month variability. There is no evidence in these data which would suggest a deterioration in the quality of health care leading to an increase in deaths at Castle Point or Montrose. As a matter of fact, the death rates in May and June of 1997 were lower than they were for most of 1996. Several media outlets which have reviewed the data as well as an independent review by a Marist College Professor of Health Care Statistics also agree with our findings. In addition, the Joint Commission on Accreditation of Healthcare Organizations recently conducted an unannounced survey and concluded that there is no cause to be alarmed about the quality of care provided to our nation's veterans. Likewise, VA's Under Secretary for Health has made a personal visit to these facilities to gather first hand information about the quality of care provided.

In regards to staffing, both hospitals are fully staffed to meet the current inpatient and outpatient workload comparable with other VA Medical Centers within this network and around the nation. While it is true that we have reduced staff at both hospitals through attrition and voluntary buyouts over the last two years, we have simply brought the staffing numbers in line with the number of patients utilizing these facilities, while eliminating redundant and duplicated layers of administration.

One critical measure of the type of care provided in the VA Hudson Valley Healthcare System is the number of veterans who are coming to us for care. If care were consistently poor and in decline we would also be likely to see a commensurate decline in the number of veterans utilizing the system. This is not the case. We have had nearly 3,500 new veterans sign up for care since 1994 with 2,000 of those veterans signing up in just the last nine months. The VA Hudson Valley facilities lead the way in terms of enrolling new veterans throughout the network.

As you know under the new funding model for VA, federal dollars will be distributed in a capitation-like manner. This process involves determining the number of category A veterans (primarily those veterans with service-connected disabilities, or those whose income falls below a particular threshold) who have received care from VA over the preceding three-year period. The actual annual cost of this care is then divided into the total number of veterans who received care to develop a national reimbursement rate. Each of the 22 VISNs then receives an allocation equal to the number of veterans treated in that VISN, multiplied by the national reimbursement rate.

A similar process is utilized to reimburse care provided to veterans with specialized needs that result in utilization of large quantities of healthcare resources. Among these veterans

are those who require organ transplants, or those who suffer with AIDS, spinal cord injuries, visual loss, or other catastrophic illnesses. VISN 3's funding allocation is adjusted for this purpose because we have a high number of special care cases.

As Director of VISN 3 I actually had to begin planning for the national funding shift in anticipation of the final projected dollar loss to our network. At the national level it was clear that under any funding model that was assembled, the Northeast and particularly VISN 3, would experience a budget reduction. Knowing that we were going to have to deal with that impact, we began planning with our staff, unions, veterans service organizations, Congressional representatives and others to try to meet the target which we believed would be approximately a $110 million loss to our network. This effort to minimize the impact of the projected loss began in October of 1995. The final VERA (Veterans Equitable Resource Allocation) reduction for our network was closer to $148 million. After months of planning and analysis we realized that our levels of workload enabled us to reduce our staffing across the network to be closer to VA national staffing numbers.

We recognized that given the proximity of our hospitals-- no other network has eight hospitals in such a small geographic area -- that we could successfully integrate the management of at least four hospitals whose missions were complementary and had a long history of sharing services and consolidated functions.

There were two priorities: adjust our staffing to clinically appropriate levels and begin to increase the number of veterans we serve so that deeper staff cuts could be avoided.

We integrated two hospitals in New Jersey and two here in the Hudson Valley. I will mention that a total of 40 medical centers nationwide have undergone successful integrations with each integrated organization becoming the responsibility of one Director. In both integrations in VISN 3 the smaller hospitals benefited from the integration with the more financially viable facilities. In the Hudson Valley, Castle Point VA Hospital did not have the patient utilization and workload to justify the staff and budget it received and therefore its integration with Montrose provided an opportunity for greater workload and financial stability. The true value of these integrations are that the staff reductions are already completed ahead of schedule and because of that, the reductions will not have to be as deep as if we did them over the next several years. By reducing staff and moving much of the savings to outpatient care and outreach to new veterans, we have strengthened all of the medical centers and enhanced their future viability. In fact the workload below demonstrates the steady increase in the number of veterans served by the VA Hudson Valley Health Care System and the resultant increase in outpatient visits.

	Oct-May	Oct-May	Oct-May
VA Hudson Valley	FY 95	FY 96	FY 97
Unique Veterans Served	12,941	13,704	15,577

Outpatient Visits	Oct-April FY 95	Oct-April FY 96	Oct-April FY 97
Castle Point	36,018	37,401	40,184
Montrose	41,270	48,108	60,607

The following are the budgets for Castle Point and Montrose for the Fiscal Year 1995, 1996 and 1997. These figures include all personnel, equipment purchases, construction and contract nursing home care.

	FY 95	FY 96	FY 97
Castle Point	$44,873,685	$41,953,801	$41,099,051
Montrose	$85,353,375	$90,918,585	$82,230,344
Total Hudson Valley	$130,227,060	$132,872,386	$128,329,395

We do recognize that these changes over the last two years, like any changes, have raised concerns which may have had an impact on morale and sense of security for our staff and veterans. But I will remind you that we have not had a RIF (reduction in force). Large scale, formalized reductions-in-force (layoffs) are not only disrupting and demoralizing but they are also costly to the government. Many other VISNs across the country are utilizing RIF Authority to reduce employment. Instead VISN 3 steadily met its goals through attrition and voluntary federal government buyouts. Given our current budget allocation and the numbers of veterans we are treating, the Hudson Valley Hospitals should not fear any further significant staff reductions.

As for the VA Medical Inspector's visit, we anxiously await the results of his team's review of the care provided to our veterans. I initially requested the review by the Office of the Medical Inspector and have ensured that the Hudson Valley Medical Centers provided their full cooperation in this important analysis. I can tell you that we are not waiting for the final report to make changes to further ensure the quality of care. Mr. Michael Sabo who is the new permanent Director of the VA Hudson Valley Health Care System has experience in operating a large two-division hospital. He brings that expertise to the Hudson Valley and following up on the excellent work done by Ms. Maryanne Musumeci, he is putting in place new mechanisms for patient /family communication and communication with our veterans leaders. His primary goal is to ensure and maintain high quality, accessible care for our veteran patients.

Finally, in addition to serving over 3,500 brand new veteran users, we have also improved access and services to veterans in the entire Hudson Valley region. We have opened a new outpatient clinic in Rockland County and have just received approval for a clinic in Yonkers. We have also expanded services in White Plains and have clinics currently in process for Kingston and Monticello. It is my desire to open a number of new clinics in all corners of the Hudson Valley to better serve our veterans. Veterans who use these

clinics are overwhelmingly satisfied with the services that are provided. A new mobile health van is also operating exclusively in the Hudson Valley to reach out to areas that have been underserved by VA and to pockets of veterans in socioeconomically disadvantaged areas, as well as direct outreach to homeless veterans in our more urban locations.

I want to thank you for the opportunity to share my thoughts with you today. Please rest assured that our first priority is compassionate, high quality care for our nation's veterans; anything less than that is unacceptable to me and to the dedicated employees of the VA Hudson Valley Health Care System.

I will gladly attempt to answer any questions you may have.

Mr. SHAYS. Thank you, Mr. Farsetta.

Dr. Wilson.

Ms. WILSON. I, too, thank the committee for the opportunity to attend this hearing and listen to the concerns of all veterans here today.

VA has multiple strategies to assess and monitor and improve the quality of care that we deliver. A number of these include credentialing and privileging, accreditation programs, and performance indicators that measure how well we deliver bread-and-butter care to veterans across the country.

In addition to that, we also have as one of our mainstays our customer feedback program that includes our patient advocacy program, our satisfaction surveys, and also our complaint assessment and tracking and resolution.

In addition to that, we have an incident review process. And, in fact, we've recently, on June 6, implemented a policy to ensure that each and every incident that results in an untoward outcome be examined in depth to assure that that event never occurs again. Such events, described as sentinel events, will now be reported to headquarters within 48 hours of their occurrence along with the reviews and recommendations for system redesign.

Our outside independent medical——

Audience PARTICIPANT. Hold it.

Audience PARTICIPANT. Hold it. Hold it.

Audience PARTICIPANT. Hold it.

Mr. SHAYS. Slight recess.

[Recess.]

Mr. SHAYS. The committee will come to order. Dr. Wilson, you have the floor again.

Ms. WILSON. Thank you.

As I had said, on June 6, we implemented a policy to ensure that each and every incident that results in an untoward outcome be examined in depth to make sure that the system is redesigned in such a way as to prevent that incident from ever occurring again. And we now require that all such sentinel events be reported to headquarters within 48 hours of their occurrence along with the reviews and recommendations for system redesign. The failure to report may result in disciplinary action. These reviews will be assessed for their adequacy by our outside and independent medical inspector's office.

In light of the need to listen to folks, that ends my testimony. And I will be happy to answer any questions.

Mr. SHAYS. Thank you, Dr. Wilson.

We will have questions, and we will begin with Mr. Gilman.

Mr. GILMAN. How about Dr. Sabo?

Mr. SHAYS. No, no. My understanding was that they were accompanying you, Mr. Farsetta?

Mr. FARSETTA. Yes.

Mr. SHAYS. And they will respond to questions and assist you? But we have two statements.

Mr. FARSETTA. Right.

Mr. SHAYS. We want to get to the service representatives. Then we want to get to the members of the audience and allow them to address this committee.

Mr. GILMAN. Thank you, Mr. Chairman.

I hope that the young lady in the back there is feeling better. I understand it was just heat exhaustion.

Mr. Farsetta, could you please explain for the committee the VA's response to those allegations that appeared in our local newspaper which allege that the mortality rate at Castle Point doubled from October 1996 to April 1997? There's been a great deal of comment with regard to that information.

Mr. FARSETTA. Well, my response to that is that we have looked at all the data. We have gone back essentially 3 years, compared the mortality rate over that period of time. We see monthly fluctuation, but we see no marked change in the mortality rate at either Castle Point, at Montrose over the past 3 years.

One of the newspapers in this area was given all the information that we had. They sent it out to an independent statistician. He reviewed the data. He arrived at the same conclusion.

Dr. Wilson could probably respond to that question since they have also looked at the data.

Ms. WILSON. Yes. The statistician in my office also looked at the data for the times in question and found no difference in the rate from 1996 to 1997 for those months. There's no statistically significant difference in the rates.

Audience PARTICIPANT. You can get stats to say anything you want.

Mr. GILMAN. Mr. Sabo, who is our new director of our Castle Point facility, can you tell us what's been done to improve communications between staff and patients since this situation started last May?

Mr. SABO. Thank you, Congressman. And it is a pleasure for me to be back in the Hudson Valley. Part of what I have instituted since I got there on July 20 was to re-energize patient councils in the nursing home units. This would be an attempt to try and solicit feedback from those patients on areas where they have concern with the quality of the food, the quality of the patient care, recreational activities.

In addition to that, I've reinstituted family council meetings at both the Castle Point and Montrose facilities, whereby representatives of the families will have a venue to come in and talk about issues regarding the care being delivered at both places.

I am going to be assessing our patient representative program to ensure that both of those—that's the ombudsman piece of our program—to make sure that they're actually listening to folks and that information is fed to me on a regular basis.

I've met with many of the county veterans' representatives already and talked to them about their concerns they have toward the facility and spoke to families.

I do have an open-door policy. If there are concerns, I certainly want to hear those. And I'll make every attempt to correct those areas that need to be corrected.

Mr. GILMAN. Thank you.

Mr. Farsetta, you've already improvised a number of reductions in staff and some of the expenditures. What future reductions in staff and services can be expected in the next 6 months?

Mr. FARSETTA. I'm not anticipating any future reductions in staff over the next perhaps year or two. I know that there was a letter that was distributed by Acting Secretary Gober or Secretary Designee Gober indicating that neither the Castle Point nor the Montrose VA facility will be closing.

Our goal essentially is to in a number of areas, as I mentioned earlier, attempt to expand services so we could reach out to more veterans in the Hudson Valley area.

I neglected to mention in my opening statement that in response to, I believe a comment made by, you, that the Chief of Medical Administration is currently meeting this afternoon with representatives from our other hospitals exploring the feasibility of providing some surgical services to the residents and veterans of the Hudson Valley area.

Mr. GILMAN. That would be contract services to the local hospitals?

Mr. FARSETTA. That's correct.

Mr. GILMAN. So they don't have to travel to Albany or to Bronx?

Mr. FARSETTA. That is correct.

Mr. GILMAN. Appreciate that.

Dr. Wilson, you're in the—we're talking about Castle Point. Dr. Wilson, what are the short-term plans for the Castle Point facility and the long-term plans? We keep hearing that Castle Point may be eventually phased out. Can you tell us what your program people are doing with regard to Castle Point?

Ms. WILSON. I would quote a letter from Dr. Kizer to the honorable Ben Gilman, Mr. Gilman, that says the Department of Veterans Affairs has no plans to close the Castle Point Medical Center.

However, I would also like to reaffirm that in accordance with Network 3's strategic plan, the following are some of the anticipated changes in service delivery models and clinical care strategies, over the next fiscal year: integration of radiology, nuclear medicine, and lab services with the Bronx VA Medical Center, development of a consolidated kitchen throughout the network utilizing cook-chill technology, development of two to three community-based clinics in the Castle Point catchment area, and initiation of a community-based mobile health van.

Mr. GILMAN. And then from what you're telling me, there is no immediate plan to close Castle Point. Am I correct?

Ms. WILSON. That's correct.

Mr. GILMAN. Nor close Montrose. Is that correct?

Ms. WILSON. That's correct.

Mr. GILMAN. Thank you.

Audience PARTICIPANT. Put it in writing.

Mr. GILMAN. My time has run, Mr. Chairman.

Ms. WILSON. It is in writing.

Mr. SHAYS. I just want to make sure that you all realize this is testimony under oath.

Mr. Hinchey.

Audience PARTICIPANT. That don't mean crap.

Mr. HINCHEY. Ladies and gentlemen, first of all, let me thank you for some things that you have talked about here this afternoon in your testimony, which I think will be helpful and will improve care for veterans.

First of all, Mr. Farsetta, you mentioned the establishment of clinics in Rockland County and in Westchester County and plans for a clinic in Kingston and one in Monticello. We have been working with you on these clinics, and I think that that is a very important and very positive step forward.

Dr. Wilson, you mentioned that there will be a number of reports that will be issued if there are untoward incidents I think you put it. I think that is very good, but let me ask you a couple of questions about that.

First of all, how would you define an untoward incident?

Ms. WILSON. We define a sentinel event in the same way that the Joint Commission of Accreditation of Hospitals does, which is permanent loss of life, limb, or function. We also——

Audience PARTICIPANT. How many civilians have that?

Ms. WILSON. Those sentinel events are what will be called into headquarters. They will be called from the facility to the network office within 24 hours of their occurrence and then 24 more hours to the headquarters office. We will then track the results of the reviews of all of those events.

Mr. HINCHEY. Is this a new policy that you've recently implemented?

Ms. WILSON. June 6, 1997.

Mr. HINCHEY. June 6 of this year? Will there be any outside review of those event reports?

Ms. WILSON. The Medical Inspector's Office will review the adequacy of the reviews that are done by the facilities and the networks in addition to our headquarters team looking for system redesign issues that we might want to implement across the country.

Mr. HINCHEY. So there will be an outside objective analysis of those reports outside of the VA itself?

Ms. WILSON. Yes.

Mr. HINCHEY. Mr. Farsetta, you mentioned in your report, in your statement, and what you say here is, "Many of our overall care indicators with respect to quality have actually improved. In addition, patient satisfaction across the network has also improved according to recent surveys."

That statement strikes at the heart, really, of my concern because, first of all, it is counter-intuitive. Second, it runs counter to all of the evidence that we have seen over the course of the last couple of years. [Applause.]

It is absolutely essential if we are going to get to the bottom of this problem—and I think we can all agree that there is a problem here. It is not just a problem of perception. [Applause.]

It is a deep and abiding problem. If we are to get to the bottom of this, we, first of all, have to confront the situation honestly and objectively.

And I must say to you, sir, that those kinds of statements, which I have heard you say before in private meetings that we have had and in meetings with the VA that we have had—I've heard you say those things before. And I just find it absolutely incredible because the fact of the matter is that we see time and time again documented examples that run completely to the contrary.

Mr. FARSETTA. I don't want to get overly defensive about that because, as I mentioned in my statement, there's clearly an issue

here. I'm going to attempt to respond to that in two ways. The VA does a survey, and Dr. Wilson can speak about it. It's a scientific instrument that's mailed out to veterans. And veterans respond to that instrument.

We have also hired the Gallup Corp. to take that instrument and utilize that instrument, mail it out to veterans in the network, specifically in the Hudson Valley area. And everyone doesn't get a questionnaire. It's sent out to a sampling, what they consider to be a statistically-significant sampling. It's mailed out.

And what the survey says, the survey doesn't say that everybody is happy with everything that's going on. What the survey results indicate, that as compared to services that veterans received last year, they are happier this year than they were last year. It doesn't mean that there aren't many areas for improvement. I'm not suggesting that, and I wouldn't suggest that.

[The survey referred to follows:]

THE GALLUP ORGANIZATION
PRINCETON

300 South 68th Street Place
Lincoln, Nebraska 68510 USA
(402) 489-8700

Dear Veteran,

You have the right to get the best health care available in the United States. The Veterans Health Administration (VHA) wants to give you that care, but we need you help. Only YOU can tell us how well we are serving you, and in what areas we could serve you better.

The questions in this survey were developed by asking veterans around the country what things were important to them when they received outpatient services. Your answers will be used by VA medical centers and VHA policy makers to help decide which areas of VA clinic care need to be improved.

Your answers will not be linked to who you are. Taking part in this survey will not in any way affect your eligibility for VA benefits.

Your answers will guide our efforts to make the VA health care system your first choice for all your health care needs.

Please return your completed questionnaire by July 28th, by mailing it in the enclosed postage paid envelope. If you have already completed this survey, please disregard this copy. If not, we would greatly appreciate your input now. We look forward to hearing from you, and thank you in advance for your help!

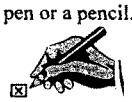
Sincerely,

Tracy Stinson
Project Director

Please answer all survey questions about your most RECENT VA Clinic visit!

About Your VA Clinic Visits

Please read each question and put an X in the box that best describes your experience.
Use blue or black ink pen or a pencil.

Please do this: 

ABOUT YOUR RECENT VA CLINIC VISIT

GETTING AN APPOINTMENT

1a. First of all, at which of the following VA Clinic locations were you most recently treated ?

(Please indicate the ONE most recent VA Clinic you have visited)

- ☐ **VA Medical Center-Bronx, NY**
  130 West Kingsbridge Road
- ☐ **VA Medical Center-Brooklyn, NY**
  800 Poly Place
- ☐ **Veteran Health Care Center-Brooklyn, NY**
  40 Flatbush Avenue Extension
- ☐ **VA New Jersey Health Care System-East Orange, NJ**
  385 Tremont Avenue
- ☐ **James J. Howard Outpatient Clinic-Brick, NJ**
  970 Route 70
- ☐ **VA Primary Care Practice Group-Hackensack, NJ**
  382 Prospect Avenue
- ☐ **VA Extended Care Center-St. Albans, NY**
  179th Street and Linden Blvd.
- ☐ **Staton Island CBC-Staton Island, NY**
  21 Water Street
- ☐ **VA Medical Center-Lyons, NJ**
  151 Knollcroft Road
- ☐ **VA Primary Care Clinic-Trenton, NJ**
  171 Jersey Street, Bldg 36
- ☐ **FDR VA Hospital-Montrose, NY**
  PO Box 100
- ☐ **VA Medical Center-Castle Point, NY**
- ☐ **VA Medical Center-New York, NY**
  23 E. 23rd Street
- ☐ **National Footwear Center-New York, NY**
  245 West Houston Street
- ☐ **Health Care for Homeless Veterans (HCHV)-New York, NY**
  312 West 36th Street
- ☐ **Opiate Substitution Treatment Program (OSTP)-New York, NY**
  437 West 16th Street
- ☐ **VA Medical Center-Northport, NY**
  79 Middleville Road
- ☐ **VA Lynbrook Satellite Clinic-Lynbrook, NY**
  235 Merrick Road
- ☐ **VA Clinic-Pomona, NY**
  Robert Yaeger Health Center
  50 Sanatorium Road-Bldg. A
- ☐ **Harlem VA Care Center-New York, NY**
  55 East 124th Street
- ☐ **Compensation & Pension Clinic-New York, NY**
  245 West Houston Street
- ☐ **VA Islip Satellite Clinic-Islip, NY**
  39 Nassau Avenue
- ☐ **VA Patchogue Satellite Clinic-Patchogue, NY**
  269 Baker Street @ S. Ocean Ave.
- ☐ **VA Riverhead Satellite Clinic-Riverhead, NY**
  89 Hubbard Avenue
- ☐ **VA Lindenhurst Satellite Clinic-Lindenhurst, NY**
  560 North Delaware Avenue
- ☐ **VA Plainview Satellite and Primary Care Clinic-Plainview, NY**
  1535 Old Country Road
- ☐ **VA Mt. Sinai Satellite Clinic-Mt. Sinai, NY**
  Mt. Sinai Community Center
  North Country Road

PLEASE CONTINUE

1b. **At that clinic location, which of the following types of clinics did you most recently visit?**

- ☐ General Medicine Clinic
- ☐ Primary Care Clinic
- ☐ Women's Clinic
- ☐ Outpatient Specialty Clinic
- ☐ Mental Health Clinic

Please answer the following series of questions regarding your most recent visit to the clinic and location you specified above.

2. **Were you able to get this clinic appointment as soon as you wanted?**

- ☐ Yes
- ☐ No

3. **Were you able to schedule this appointment the first time you tried?**

- ☐ Yes
- ☐ No

4. **Was the person who made your appointment courteous?**

- ☐ Yes, definitely
- ☐ Yes, somewhat
- ☐ No

ARRIVAL AND REGISTRATION

5. **On the day of the appointment, how long did you wait in line to register?**

- ☐ Less than 15 minutes
- ☐ 15 to less than 30 minutes
- ☐ 30 minutes or longer

6. **What do you think is a reasonable amount of time to wait in line to register?**

- ☐ Less than 15 minutes
- ☐ 15 to less than 30 minutes
- ☐ 30 minutes or longer

7. **How long after the time when your appointment was scheduled to begin, did you wait to see the doctor (or other "provider")?**

- ☐ 1 to 10 minutes
- ☐ 11 to 20 minutes
- ☐ 21 to 30 minutes
- ☐ 31 to 60 minutes
- ☐ More than 1 hour
- ☐ No wait
- ☐ Can't remember

8. **What do you think is a reasonable amount of time to wait to see the doctor (or other "provider"), after the time when your appointment was scheduled to begin?**

- ☐ 1 to 10 minutes
- ☐ 11 to 20 minutes
- ☐ 21 to 30 minutes
- ☐ 31 to 60 minutes
- ☐ More than 1 hour
- ☐ No wait

IN THE PROVIDER'S OFFICE

9. **When you saw the provider, did he or she give you a chance to explain the reasons for your visit?**

- ☐ Yes
- ☐ No
- ☐ Provider already knew

10. **Did the provider listen to what you had to say?**

- ☐ Yes, completely
- ☐ Yes, somewhat
- ☐ No
- ☐ Had nothing to discuss

11. **Were you involved in decisions about your care as much as you wanted?**

- ☐ Yes, definitely
- ☐ Yes, somewhat
- ☐ No

12. **Was the provider willing to talk to your family or friend about your health or treatment?**

    ☐ Yes
    ☐ No
    ☐ No family/friends involved

13. **Did the provider ask how your family or living situation might affect your health?**

    ☐ Yes
    ☐ No
    ☐ Not necessary

14. **Did your provider look you in the eye when you talked, rather than at your chart or elsewhere?**

    ☐ Yes, always
    ☐ Yes, sometimes
    ☐ No

15. **Did you have concerns that you wanted to discuss but did not?**

    ☐ Yes
    ☐ No

16. **If you and the provider did not talk about your concerns, was it because...**

    ☐ You were embarrassed about bringing them up
    ☐ Provider didn't have time to listen
    ☐ You forgot to bring them up
    ☐ You didn't have time to bring them up
    ☐ Some other reason
    ☐ Did not have concerns

17. **Did your provider encourage you when you tried to improve your health (diet, exercise, smoking)?**

    ☐ Yes
    ☐ No
    ☐ Didn't need to improve

18. **Were you treated with courtesy and respect by the provider?**

    ☐ Yes, completely
    ☐ Yes, somewhat
    ☐ No

19. **Did you have confidence and trust in the provider you saw?**

    ☐ Yes, completely
    ☐ Yes, somewhat
    ☐ No

20. **Did you have trouble talking with the provider because of a language problem?**

    ☐ Yes, definitely
    ☐ Yes, somewhat
    ☐ No

21. **When you asked questions, did you get answers you could understand?**

    ☐ Yes, always
    ☐ Yes, sometimes
    ☐ No
    ☐ Didn't ask any questions

22. **Did the provider explain why you needed tests in a way that you could understand?**

    ☐ Yes, completely
    ☐ Yes, somewhat
    ☐ No
    ☐ Didn't need any tests

23. **After tests were done, did the provider explain the results in a way that you could understand?**

    ☐ Yes, completely
    ☐ Yes, somewhat
    ☐ No
    ☐ Did not get results yet
    ☐ Didn't need explanation
    ☐ Didn't need any tests

24. Did someone explain the purpose of any prescribed medicines in a way you could understand?

- ☐ Yes, completely
- ☐ Yes, somewhat
- ☐ No
- ☐ Already knew
- ☐ No medicines prescribed

25. Did someone tell you about side effects of the medicines in a way you could understand?

- ☐ Yes, completely
- ☐ Yes, somewhat
- ☐ No
- ☐ Already knew
- ☐ No medicines prescribed

26. Did the provider explain what to do if problems or symptoms continued, got worse, or came back?

- ☐ Yes, completely
- ☐ Yes, somewhat
- ☐ No

27. Did you get as much information about your health and/or treatment as you wanted from the provider?

- ☐ Yes
- ☐ No

OVERALL IMPRESSION OF YOUR MOST RECENT CLINIC VISIT

28. How would you rate the overall quality of care?

- ☐ Poor
- ☐ Fair
- ☐ Good
- ☐ Very Good
- ☐ Excellent

29. All things considered, how satisfied were you with the care and service provided at this visit?

- ☐ Very dissatisfied
- ☐ Somewhat dissatisfied
- ☐ Somewhat satisfied
- ☐ Very satisfied
- ☐ Completely satisfied, couldn't be better

29a. If you were dissatisfied with the care and service, please list the main reasons why.

_____

_____

_____

_____

_____

_____

_____

_____

ABOUT YOUR CLINIC VISITS DURING THE PAST TWO MONTHS

Now please think about all of the care you have received in the past two months at a VA clinic, VA doctor or nurse's office, or a VA emergency room.

30. Is there one provider or team in charge of your VA care?

- ☐ Yes
- ☐ No
- ☐ Not sure

31. Were the providers who cared for you always familiar with your most recent medical history?

- ☐ Yes
- ☐ No

32. Were there times when one of your providers did not know about tests you had or their results?

- ☐ Yes
- ☐ No
- ☐ No tests

33. Were there times when one of your providers did not know about changes in your treatment that another doctor recommended?

- ☐ Yes
- ☐ No

34. Were there times when you were confused because different providers told you different things?

- ☐ Yes
- ☐ No

35. Did you always know what the next step in your care would be?

- ☐ Yes
- ☐ No

36. Did you know who to ask when you had questions about your health care?

- ☐ Yes, always
- ☐ Yes, sometimes
- ☐ No
- ☐ Didn't have any questions

37. If there was a time in the past two months when you needed medical advice or help right away, how long did it take to get the help you needed?

- ☐ No wait
- ☐ Within 1 hour
- ☐ More than 1 hour, but within 24 hours
- ☐ Greater than 24 hours
- ☐ Never got the help I needed
- ☐ Never needed help

38. Do you think your problem should have been handled sooner?

- ☐ Yes
- ☐ No
- ☐ Never needed help

OVERALL IMPRESSION OF YOUR CLINIC CARE IN THE PAST TWO MONTHS

39. Overall, how would you rate the quality of the VA Clinic care you have received over the past two months?

- ☐ Poor
- ☐ Fair
- ☐ Good
- ☐ Very Good
- ☐ Excellent

40. How satisfied are you with the care you have received in the past two months?

- ☐ Very dissatisfied
- ☐ Somewhat dissatisfied
- ☐ Somewhat satisfied
- ☐ Very satisfied
- ☐ Completely satisfied, couldn't be better

41. Did you feel that you were treated like a second class citizen?

- ☐ Yes
- ☐ No

42. Did you ever complain to someone about the care you got?

- ☐ Yes
- ☐ No

42a. Did you ever complain to:

A. a patient representative

☐ Yes ☐ No

B. someone else in the medical center (other than a patient representative)

☐ Yes ☐ No

C. a VA official outside the medical center

☐ Yes ☐ No

43. Would you recommend this VA clinic to other veterans if they needed care?

☐ Definitely would not
☐ Probably would not
☐ Probably would
☐ Definitely would

44. If you could have free care outside the VA, would you choose to come here again?

☐ Definitely would not
☐ Probably would not
☐ Probably would
☐ Definitely would

45. How often would you say that VA medical care is as good as that provided anywhere in the private sector?

☐ Never or almost never as good
☐ Rarely as good
☐ Sometimes as good
☐ Often as good
☐ Almost or almost always as good

CONCLUDING RATINGS

46. Overall, how satisfied have you been with the care you have received in the past two months at all of the VA PRIMARY CARE CLINICS you may have visited? This would include any visits you may have made to the General Medicine Clinic, the Primary Care Clinic and the Women's Clinic. Please don't include in your rating any Outpatient Specialty Clinics you may have visited. Overall, how satisfied would you say you have been with the primary care visits?

☐ Very dissatisfied
☐ Somewhat dissatisfied
☐ Somewhat satisfied
☐ Very satisfied
☐ Completely satisfied, could not have been better
☐ No primary care visits over the past 2 months

47. Again, over the past two months, how satisfied have you been with the care you have received at all of the VA SPECIALTY CARE CLINICS you may have visited?

☐ Very dissatisfied
☐ Somewhat dissatisfied
☐ Somewhat satisfied
☐ Very satisfied
☐ Completely satisfied, could not have been better
☐ No specialty care visits over the past 2 months

BACKGROUND

Answering the following questions will help us compare the quality of care given to patients with different needs and VA experiences.

D1. What is the last year of school you have completed?

- ☐ Did not complete high school
- ☐ High school graduate or GED
- ☐ Some college
- ☐ College graduate or beyond

D2. Overall, how would you rate your health?

- ☐ Poor
- ☐ Fair
- ☐ Good
- ☐ Very good
- ☐ Excellent

Thank you for your cooperation. Please return your completed survey in the envelope provided by July 21, 1997.

Mr. HINCHEY. I think that it's important for us to look at this again comprehensively and objectively. And I am going to forward to you copies of the complaints that we have received in our office. They are numerous, one might say legional. And I know that the other members of the committee have received more, I believe, in most instances than I have.

And I would ask that they be factored into this analysis so that we do not have a kind of rose-colored glasses analysis of this situation and that we look at it carefully and objectively and completely and do so in the context of the information that has come to us in addition to the survey that you have received.

There is something called the "Farsetta report." Now, I have not seen the "Farsetta report," but I am anxious to do so. And I have asked the VA on several occasions if they would kindly make available to us a copy of that report. I hope that we will get a copy of that report directly so that we can give it some careful analysis.

I know that the report was some time ago, but it has been reported to us that many of the actions taken by Under Secretary Kizer have been driven to a large extent by the recommendations contained in the Kizer report. Is that accurate?

Mr. FARSETTA. There certainly were recommendations in that report. I happened to chair a committee. And that report specifically was looking at some fairly substantial funding reductions in the VA.

I think that as it relates, for example, to some of the integrations and as it relates to combining some administrative services, I think that there are similarities. But I don't think that there are many similarities or an overwhelming variety of similarities between the "Farsetta report," which probably was done in maybe 1992, 1993 or 1994, and what's currently going on. There certainly are some items that are of a similar nature.

[The letter and the report referred to follows:]

DEPARTMENT OF VETERANS AFFAIRS
UNDER SECRETARY FOR HEALTH
WASHINGTON DC 20420

AUG 26 1997

The Honorable Sue Kelly
House of Representatives
Washington, DC 20515

Dear Congresswoman Kelly:

I am writing in response to your recent unfounded allegations that performance awards for VHA Network Directors are based on achieving dramatic budget reductions.

First, you should know that the VISN Directors are not in a position to reduce or increase their total budgets. These administrators are provided with an annual operating budget and are expected to provide services and programs within the confines of that budget authority. The primary resource management expectation for any federal official, including all Network Directors and all VA Medical Centers Directors, is to operate their facility or program within the budget they are given, just as I have to operate the Veterans Health Administration within the total budget provided by Congress. Network Directors have no authority to cut the budget deeper than what is provided to them as an annual operating budget.

Additionally, you allege that the Network Director's Performance Agreement is evidence of incentive to reduce the budget. I will tell you that the twenty-two Network Directors nationwide, only three received an award for outstanding performance. Two of those Network Directors were in regions that received additional funding under the Veterans Equitable Resource Allocation Model (VERA) and one, Mr. James Farsetta of New York/New Jersey (VISN 3), was in a region that lost funding under the new model.

The performance agreements are overwhelmingly clinically and programmatically focused on areas such as Program Administration, Patient Care Assessment, Human Resource Management, Resource Management and Qualifying Measures. Of these, only one is focused on resource management. In the area of resource management there is no incentive to reduce the budget, as explained above. The expectation is that the director will effectively manage within the parameters of the budget that is provided.

At the recent hearing you read a list of items that are a sub-category of the Qualifying Measures which includes fifteen items. Each of the items in that list are incentives to improve our clinical practices in VA – i.e., to bring VA clinical practices in line with the best of private sector standards. None of these sub-categories is a resource-driven measure. If it would be helpful for you to better understand these measures, we would be pleased to go through each item with you or your staff to discuss what they mean and the reason they were included in the Network Directors' agreements.

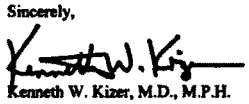
2.

The Honorable Sue Kelly

I hope this clarifies your confusion about the performance rating of VISN Directors. Mr. Farsetta has done an outstanding job. He has had one of the greatest challenges of all Networks in the nation. He has worked effectively with each of his medical center directors and various stakeholders to implement new innovative programs that bring his Network more in line with national practice standards.

Of note, some of VISN 3's accomplishments in the past year include the following: a large majority of patients now have their own personal primary care physicians; it is easier for patients to access care because of seven new satellite clinics; VISN 3 is serving more veterans across the Network, especially in the Hudson Valley and New Jersey; standardized clinical guidelines have been established for major diagnostic conditions; VISN 3 now leads the nation in accurate/completed compensation and pension physical exams for veterans; enhanced capability for ambulatory surgery allows veterans state-of-the-art surgical care on an outpatient basis when clinically appropriate; and a new network-wide nurse call 800 number has been established so that veterans may have their medical questions answered 24 hours a day. Mr. Farsetta's efforts have greatly improved the administration of care at the medical centers in his network, and he has begun the process of fostering Network-wide initiatives that will further improve the quality and access of care for all area veterans.

Sincerely,



Kenneth W. Kizer, M.D., M.P.H.

cc: Congressman Shays
Congressman Gilman
Congressman Hinchey

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EXECUTIVE SUMMARY

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Introduction

The purpose of this report is to recommend management improvements that promote efficiency and cost reductions. Such improvements are necessary given budget constraints and the need to become financially competitive in the national health care arena. Recommendations provided are categorized by 1) Capital Accounts/Activations, 2) Corporate Overhead, 3) Management Reductions/Consolidations, 4) Program/Service Adjustments 5) Contracting, and 6) VSA Initiatives. Potential FTE reductions and cost savings associated with the recommendations are defined as short-term (FY 1995), mid-term (FY 1996-1997), or long-term (FY 1998 and beyond).

Background

In January 1994, the Associate Chief Medical Director for Operations charged Mr. James Farsetta, Director, VAMC Brooklyn, to chair a task force to examine ways in which cost reductions through management improvements/efficiencies could be achieved. As Chairman of the RPM Field Oversight Committee, Mr. Farsetta convened the Committee for this assignment. The Committee, having field, region and central office representation, focused on eliminating corporate overhead/programs, eliminating supervisory layers, consolidating clinical and administrative functions, and contracting for services.

Budget

The FY 1995 budget requires 1) Management Improvements that generate savings of $49.6 million/852 FTE and 2) contracting out 4,941 FTE. However, it is believed that the FY 1995 budget problem will be even more severe. Last fiscal year, VHA was approximately $300 million short in fully implementing RPM (RPM Option 2i required a $193M increase less the $31M provided for implementation and VHA reduced Contract Hospital/Fee Basis $20M, State Home $15M, NRM $75M and strategic initiatives $25M) and this was with a $1 billion budgetary increase. VHA is currently preparing the FY 1995 RPM target allowance and a true deficit is not yet known. However, it is the belief of many on the committee that the FY 1995 shortfall may be closer to the range of $300M to $700M once RPM projections and the VACO budget call is tabulated. In any event, the impact on the field operations will be severe when you consider a reduction of 5,800 or more FTE.

Assumptions and Guiding Principles

Cost reduction recommendations are based on the following guiding principles:

- Cost saving initiatives will not significantly impact workload in terms of unique patients.
- Quality and access to care will not be compromised.
- Cost saving initiatives will be measured by the 'value added' to patient care.
- VA's competitive position for national health care reform will be improved.
- RIF and contracting authority will be an available option to the VA.

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CONFIDENTIAL

Summary

Some of the proposed changes are dramatic, but they are necessary given budget constraints and the need to position ourselves for national health care reform. Cost reduction options, for the most part, are the result of reducing FTE, which will require RIF authority. The magnitude of the reduction of FTE will be difficult to achieve without a reduction in force. It is estimated that each RIF can cost an average of $36,233 ($36.3 million/1,000 employees). To implement many of the proposed recommendations, VHA will be faced with an 'up front' fee to gain future savings. However, VHA should begin to view the events of 'right sizing' the system as an investment. Since the initial costs to become more efficient can be substantial, VHA should look at the Investment Fund as a potential resource for this effort.

The report that follows provides a brief explanation of the recommendations by the categories identified in the introduction, along with the estimated FTE and cost savings. This is then followed by more detailed information and cost data. Given the various recommendations and the possibility of overlaps, there may be some minor duplication of estimated savings. The following summarizes the FTE and cost savings:

Category Summary

	FTE			Amount		
	Short	Mid	Long	Short	Mid	Long
Capital	0	0	0	0	0	0
Activations	512	0	0	83,700,000	0	0
Corporate Overhead	312	1,020	0	31,870,488	75,010,798	0
Mngt. Reductions/Cons.	364	5,497	727	16,060,295	255,722,059	32,120,589
Program/Svc Reductions	82	572	163	93,186,134	40,019,939	11,434,268
Contracting	3,954	11,214	3,203	7,072,256	49,505,790	14,144,511
VSA Initiatives	10	1,192	4,720	529,618	58,683,532	301,059,236
Total	5,234	19,495	8,813	232,418,791	478,942,118	358,758,604
Grand Total			33,542			$1,070,119,513

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CATEGORY 1
Capital and Activations

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Most actions being recommended to 'right size' our medical care system will result in mid- or long-term savings. Consolidations and reductions of programs/services usually provide very little, if any, immediate savings. It, therefore, becomes necessary to utilize capital and activation accounts to produce short-term savings. However, because of the capital account restriction, a significant portion of the capital resources are not available until August 1 of the fiscal year and must be used for either land, structure, or equipment, thus reducing VHA's flexibility to reprogram dollars. Depending on the outcome of other recommendations provided in this document, it may become necessary for the VA to request relief from the capital account restriction.

Recommendations:

- After all other budgetary reductions have been determined, any remaining identified shortfall be offset with funds from the capital investment program.

  Estimated Available in FY 1995: $0-$900 million

  (In addition, $651 million is available in the FY 1994 appropriation as a result of the capital account restriction. These funds cannot be obligated until after August 1994 and could be available, if necessary, for a short-term solution.)

- All FY 1995 (and 1994) activations be reviewed by the regions to determine increases of new unique patients. No recurring FTE be provided for clinical improvements or program enhancements, except when new patients will be served. To the extent possible, request the reprogramming of community nursing home funds to support the activation of VA nursing homes when community based workload can be brought in-house.

Estimated Savings	FTE	Funds
Short-term	512	$83,700,000

Attachment A
1) Capital/Activation
2) Activation

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CATEGORY 2
Corporate Overhead

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Corporate overhead is classified as medical care expenditures that are national in scope, not facility specific, and have no influence on workload levels. Corporate overhead has been divided into five classifications.

1) **Centralized Accounts** - Contracts and activities administered at the central office level.

2) **National Field Units** - An office/unit responsible for oversight, evaluation, and/or developmental/analytical work.

3) **National Program Office** - Decentralized VACO management offices.

4) **Research Centers** - Directors of special research centers that are currently paid from medical care.

5) **National Training Programs** - Training programs administered at the central office level.

The objective of reviewing corporate overhead is to (1) minimize funds maintained at central office level by emphasizing decentralization of as many activities and responsibilities as possible and (2) promote efficiency and quality by requiring corporate activities to become 'self-sustaining' by offering to sell their service/product.

Recommendations:

• Centralized Accounts - In recent years, VHA has decentralized accounts such as FTS, Federal Employee Compensation Program (FECP), and postage. Continue to emphasize the reduction and decentralization of centralized accounts to maximum extent possible.

Specifically, no additional medical care funding be provided to support DMMS/DSS. MCCR funds and the Investment Fund should be considered for any future funding requirements relative to DMMS/DSS, and additional funding, regardlesss of the source, be contingent upon the success at the 10 initial sites

Estimated Savings	FTE	Funds
Short-term	152.8	$14,141,191
Mid-term	216.2	$15,955,094
Total	369.0	$30,096,285

• National Field Unit - Minimize the 'off the top' funding of National Field Units. Eliminate as many of the current offices as possible, or at least reduce their cost. Establish the policy that newly activated field units require the approval of the Under Secretary for Health and must be chartered with a formal mission statement that includes a sunset provision. All future units be self-supporting by selling their service/product to medical care facilities or be funded on a non-recurring basis if, for example, specifically identified in the appropriation.
Examples: National Engineering Service Center, Quality Management Institute, and Information Systems Center (ISC)

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Estimated Savings	FTE	Funds
Short-term	55.3	$7,053,427
Mid-term	690.4	$45,239,921
Total	745.7	$52,293,348

• National Program Office - Clinical Program in VACO should be administered by a small professional staff. As a collateral assignment, colleagues in the field provide technical support to the Clinical Program office. Certain medical centers should be designated 'centers of excellence' for a particular program area. Medical care and MAMOE savings can be achieved by this action.
Example: Audiology/Speech Pathology

Estimated Savings	FTE	Funds
Short-term	4.0	$286,621
Mid-term	51.8	$3,824,944
Total	55.8	$4,111,565

• Research Centers - Discontinue funding the Directors' salaries from medical care for specially designated research centers.
Example: Alcohol Research Center

Estimated Savings	FTE	Funds
Mid-term	11.5	$1,542,660

• National Training Programs - Minimize the 'off the top' funding for national training programs and emphasize decentralization. Reorganize so that national training becomes a 'self-sustaining' program by selling their service/product to the medical centers.
Examples: Engineering Training Center and RMEC.

Estimated Savings	FTE	Funds
Short-term	100.0	$10,389,249
Mid-term	50.5	$8,448,179
Total	150.5	$18,837,428

• Other - Although no potential cost savings were estimated in some cases, there are other corporate expenses that should receive further review and analysis.
Examples: National Hearing Aid Program and Substance Abuse/PTSD accounts.

Total Estimated Savings - Corporate Overhead

Estimated Savings	FTE	Funds
Short-term	312.1	$31,870,488
Mid-term	1,020.4	$75,010,798
Total	1,332.5	$106,881,286

Attachment B
Corporate Account Detail Information

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Category 3
MANAGEMENT REDUCTIONS/CONSOLIDATIONS

This category focuses on reducing 'management layers' and streamlining operations. Opportunities to eliminate the number of supervisory positions and consolidate medical center functions have been identified and evaluated in terms of their ability to achieve maximum efficiencies in operations, while minimizing disruption in patient services and access to care. The following five principle changes are identified:

- **Supervisory** - A horizontal elimination of certain supervisory positions.
- **Services** - Consolidation/Realignment of Services within facilities.
- **Outpatient Clinics/Domiciliary** - Consolidation of administrative functions of independent outpatient clinics/domiciliary with a parent VAMC.
- **Two and Three Division VAMCs/Administrative Services** - Consolidation of two or three medical care facilities to eliminate administrative and clinical management overlap. Also, consolidate administrative activities at various medical centers to one central site.
- **VHA/VBA** - Consolidation of administrative functions of VAMCs and VA Regional Offices.

This category, which will reduce management, fits well with National Performance Review and is greatly enhanced with the option of 'early out' retirements. There may not be a more perfect opportunity to reorganize our management structure then the present time. With an early out incentive, the prospect of consolidating medical centers and administrative services to steamline our system is substantially improved.

Recommendations:

- Eliminate the following supervisory positions:

  1. Abolish Assistant Chief positions in Administrative and Ancillary Support Services: Engineering, Environmental Management, Acquisition and Materiel Management (A&MMS), Fiscal, Personnel, Medical Administation (MAS), Dietetics, Pharmacy, Security, Prosthetics, Chaplain, Voluntary, Information Resource Management (IRMS), Social Work (SWS), Psychology.

Estimated Savings	FTE	Funds
Short-term	148.0	$8,486,857
Mid-term	1,036.0	$59,407,999
Long-term	296.0	$16,973,714
Total	1,480.0	$84,868,570

  2. Abolish all Assistant Director positions and one clerical support position.

Estimated Savings	FTE	Funds
Short-term	8.0	$437,944
Mid-term	56.0	$3,065,608
Long-term	16.0	$875,888
Total	80.0	$4,379,440

3. Readjustment Counseling Service - Outreach Centers should be integrated into VAMC management, thereby reducing corporate overhead (VACO and Regions). Medical care and MAMOE savings can be achieved.

Estimated Savings	FTE	Funds
Short-term	7.0	$288,494
Mid-term	46.0	$2,019,457
Long-term	13.0	$576,988
Total	65.0	$2,884,939

- Consolidate/Realign the following services:

1. Consolidate Recreation Therapy and Voluntary Service into one Service

Estimated Savings	FTE	Funds
Short-term	20.0	$770,297
Mid-term	140.0	$5,392,077
Long-term	40.0	$1,540,594
Total	200.0	$7,702,968

2. Consolidate Eng. & Environment Mgnt. Svcs. - Plant Mgnt. Service

Estimated Savings	FTE	Funds
Short-term	121.0	$4,350,249
Mid-term	847.0	$30,451,743
Long-term	242.0	$8,700,498
Total	1,210.0	$43,502,490

3. Realign Medical Administration Service and assign functions to other services, e.g., Ward Administration assigned to Nursing Service and Office Operations assigned to IRMS. This would eliminate the need for some managerial positions.

Estimated Savings	FTE	Funds
Short-term	60.0	$1,726,454
Mid-term	420.0	$12,085,175
Long-term	120.0	$3,452,907
Total	600.0	$17,264,536

- Independent outpatient clinics and domiciliary - Freestanding, independent outpatient clinics are no longer conducive to management efficiencies. Consolidate independent outpatient clinics and domiciliary within the contiguous U.S. with a parent medical center. Consolidate:

Outpatient Clinic	Parent Facility
Columbus	Chillicothe
El Paso	Albuquerque
Las Vegas	Loma Linda
Los Angeles	West Los Angeles

Domiciliary	Parent Facility
White City	Roseburg

Estimated Savings	FTE	Funds
Mid-term	125.0	$6,250,000

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- Two and three division medical centers/administrative services:

1. There are a number of medical centers that are geographically close and have complementary missions and existing referral mechanisms which lend themselves to consolidation.

Medical Center Consolidations:

Region 1
Bedford/Boston
Castle Point/Montrose
Philadelphia/Wilmington
Buffalo/Batavia
Lyons/East Orange
Pittsburgh UD/Pittsburgh HD/Butler
Canandaigua/Bath
Baltimore/Fort Howard
West Haven/Newington
Beckley/Huntington

Region 2
Leavenworth/Kansas City
Indianapolis/Fort Wayne
Saginaw/Allen Park
Des Moines/Iowa City
Minneapolis/St. Cloud
Lincoln/Grand Island
Hot Springs/Fort Meade
Chicago Westside/Lakeside

Region 3
Temple/Marlin/Waco
Bonham/Dallas
San Antonio/Kerrville
Murfreesboro/Nashville
Montgomery/Tuskegee
Bay Pines/Tampa
Gainesville/Lake City

Region 4
Walla Walla/Spokane
San Francisco/Livermore
Phoenix/Prescott
Seattle/American Lake

Estimated Savings	FTE	Funds
Mid-term	1,457.0	$72,850,000

2. There is further potential for consolidation of administrative functions, e.g., Fiscal, Acquisition and Materiel Management, Personnel, Engineering, Environmental Management, and IRM, in addition to the above medical center consolidations, that would generate additional savings.

Administrative Consolidations:

Region 1
Bedford/Boston/Brockton/Manchester
Baltimore/Washington DC/Perry Point/Fort Howard
Buffalo/Batavia/Bath/Canandaigua
Bronx/New York/Montrose/Castle Point
Brooklyn/East Orange/Lyons/Northport
Pittsburgh HD/Pittsburgh UD/Altoona/Butler

Region2
Columbus/Dayton/Chillicothe/Cinncinatti
Ann Arbor/Battle Creek/Toledo/Allen Park/Saginaw
Fort Wayne/Marion, IN, Indianapolis/Danville, IL
Chicago Hines/West Side/Lake Side/North Chicago
Milwaukee/Madison/Tomah
Iowa City/Des Moines/Knoxville
Omaha/Lincoln/Grand Island

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CATEGORY 4
Program/Service Adjustments

To be competitive, VHA will be required to reduce expenses for 1) services that typically are not offered to patients or employees in the private sector and 2) services that can be obtained from another source. The objective is to reduce the unit cost of patient care without adversely impacting quality. In some cases, VHA will not necessarily have to reduce the service, but can simply utilize resources that are available in the local community with little, or no, cost.

Recommendations:

• Beneficiary travel (Eliminate) - Currently, beneficiary travel is an 'all or nothing' discretionary item, and, therefore, the savings estimated represent total cost of beneficiary travel. However, it is proposed that the VA develop legislation to change beneficiary travel requirements to include only emergency travel.

Estimated Savings	Funds
Short-term	$83,779,000

• Patient Clothing - Eliminate the routine provision of VA pajamas, robes and slippers (particularly flame retardant pajamas in VAMCs that are smoke free and equipped with sprinkler systems).

Estimated Savings	Funds
Short-term	$3,690,000

• Employee uniforms - Discontinue the purchase, replacement, laundry and allowance for employee uniforms.

Estimated Savings	FTE	Funds
Short-term	14.0	$1,607,265
Mid-term	95.0	$11,250,855
Long-term	27.0	$3,214,530
Total	136.0	$16,072,650

• Dialysis - Reduce dialysis costs by 25% ~~eliminating~~ Reducing chronic dialysis treatment, providing only acute dialysis services.

Estimated Savings	FTE	Funds
Short-term	12.0	$1,249,139
Mid-term	87.0	$8,743,974
Long-term	25.0	$2,498,278
Total	124.0	$12,491,391

• Fire Protection Service - To the extent possible, close VHA fire protection services where the local municipality is responsible for providing fire protection.

Estimated Savings	FTE	Funds
Short-term	23.0	$880,044
Mid-term	159.0	$6,160,307
Long-term	45.0	$1,760,088
Total	227.0	$8,800,439

Leavenworth/Kansas City/Topeka
St. Louis/Columbia/Marion, IL

Region 3
Montgomery/Tuskegee/Tuscaloosa/Birmingham
Atlanta/Augusta/Dublin
columbia/charleston
Bay Pines/Tampa/Lake City/Gainesville
Mountain Home/Asheville/Salisbury
Fayetteville/Durham

Region 4
Sepulveda/LAOPC/West LA/Long Beach/San Diego
Palo Alto/San Francisco/Livermore/Martinez

Estimated Savings	FTE	Funds
Mid-term	1,066.0	$53,300,000

• VHA/VBA - Consolidate administrative functions where VA Regional Offices and VA medical centers are closely located.

Estimated Savings	FTE	Funds
Mid-term	304.0	$10,900,000

Total Estimated Savings - Management Reductions/Consolidations

	FTE	Funds
Short-term	364.0	$16,060,295
Mid-term	5,497.0	$255,722,059
Long-term	727.0	$32,120,589
Total	6,588.0	$303,902,943

Attachment C
1) Management Reductions/Consolidation Worksheets
2) VHA/VBA consolidation

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• Chaplain Service - VA should reduce Chaplain Service by coordinating with the community. A Chaplain coordinator and a progam assistant will be retained at each medical center.

Estimated Savings	FTE	Funds
Short-term	33.0	$1,980,686
Mid-term	231.0	$13,864,803
Long-term	66.0	$3,961,372
Total	330.0	$19,806,861

• Domiciliary Care - Domiciliaries serve veterans who, for various reasons, have special needs for custodial care but do not require ongoing access to medical resources in an inpatient setting. Since the inception of the VA domiciliary program, 100% of the operating cost has been borne by the VA for those residents who participate in the program. Recommendations have been made in the past to alter the system, changing it to one that would be more of a residential treatment type program requiring the veteran to share or absorb the cost of care similar to the privately-based residential care programs we currently use for outplaced veterans. Similar efforts have been developed through the mental health initiative program and have been very successful in outplacing long-term care institutionalized psychiatric patients into community-based residential care homes. The only difference in this proposal is that the VA continue to maintain residential care domiciliary programs and simply offset part of the cost by collecting other resources available to the veterans, such as social security payments, VA pension payments, and other income sources.

Estimated Savings: Because of the uncertainty regarding the offsets for this particular recommendation, no cost reduction is estimated.

Total Estimated Savings - Program/Service Reductions

	FTE	Funds
Short-term	82.0	$93,186,134
Mid-term	572.0	$40,019,939
Long-term	163.0	$11,434,268
Total	817.0	$144,640,341

Attachment D

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Category 5
CONTRACTING

Additional emphasis is placed on utilizing contractual services to reduce FTE. The review focuses on identifying services that would have the least disruption to patient care. In determining potential FTE impact, it is assumed that only half of the medical centers will be able to contract because of the availability of services in a given area and FTE savings are calculated at 10% (Short-Term), 70% (Mid-Term), and 20% (Long-Term). In addition, reductions are given by FTE alone, because the cost of contracting will vary depending on the competition in a given location. The only exception pertains to Psychology Service, where it is estimated that approximately 50% of the current cost might be saved by reducing the number of psychologists currently employed.

Recommendations:

- Consideration should be given to contracting the following services:

	FTE			
	Short	Mid	Long	Total
Psychology	130	909	260	1,299
Dental	136	954	272	1,362
Environmental Management	612	4,281	1,223	6,116
Food Service (Excl. Dietitians)	504	3,525	1,007	5,036
Organ Transplants	7	52	15	74
Laundry	75	522	149	746
Medical and Dental Residents*	2,351	0	0	2,351
Medical Media	22	152	43	217
Security	117	819	234	1,170
TOTAL	3,954	11,214	3,203	18,371

	Amount			
	Short	Mid	Long	Total
Psychology	$7,072,256	$49,505,790	$14,144,511	$70,722,557

*Also, trainee FTE be retained at current level (no expansion).

- Although not medical care FTE, consideration should also be given by the VA to contracting out Canteen services and the MCCR functions.

Total Estimated Savings - Contracting

	FTE	Funds
Short-term	3,954.0	$7,072,256
Mid-term	11,214.0	$49,505,790
Long-term	3,203.0	$14,144,511
Total	18,371.0	$70,722,557

Attachment E

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Category 6
VSA INITIATIVES

There are additional initiatives identified for potential cost savings, but are considered to be more appropriately addressed at the VSA level. These initiatives include 1)surgical realignment, 2) the option to consolidate Psychiatry, Psychology and Social Work Services into a Mental Health and Behavioral Science Service, 3) consideration to consolidate Fiscal and Aquistion and Material Management, and 4) workload realignments / mission changes.

Recommendations for VSAs:

- Realign Surgical Workload - Realign surgical workload at facilities 1) identified in the FY 92 VHA Surgical Realignment Study and 2) where surgical ADC is less than 15.

Estimated Savings	FTE	Funds
Mid Term	1,062.0	$52,576,207

- VAMCs should be given the flexibility to structure mental health services to best meet patient care needs, as separate services or as a consolidated service (Mental Health and Behavioral Science Service).

Estimated Savings	FTE	Funds
Short-term	10.0	$529,618
Mid-term	70.0	$3,707,325
Long-term	20.0	$1,059,236
Total	100.0	$5,296,179

- VAMCs should be given the flexibility to structure Fiscal and Acquistion and Material Management as separate services or as a consolidated service (Business Service).

Estimated Savings	FTE	Funds
Mid-term	60.0	$2,400,000

- Workload realignments/mission changes - There have been various studies at the national level that demonstrate a great potential to realign inpatient workload within the current system of medical centers. Although cost estimates and particular facilities identified may be argued, there is agreement among most that there is potential for long term savings by realigning inpatient workload. Estimated savings demonstrated in the Workload Realignment Report Survey dated May 1, 1992, are approximately $300 million. It is the committee's decision, however, that these major decisions and cost reduction potentials can best be addressed and assessed by VSA organizations, a level of the organization which is closer to local issues and priorities.

Estimated Savings	FTE	Funds
Long-term	4,700.0	$300,000,000

Total Estimated Savings - VSA Initiatives

	FTE	Funds
Short-term	10.0	$529,618
Mid-term	1,192.0	$58,683,532
Long-term	4,720.0	$301,059,236
Total	5,922.0	$360,272,386

Attachment F

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ATTACHMENT A
Capital Investment Program and Activation

FY 1995 Budget Estimates

	FTE	Funds (000)
Equipment (Existing Facilities)		$429,792.
Lands and Structures (NRM)		$283,549
Capital Leases		$14,116
Activation Capital Investment		$163,976
Subtotal Capital Investment		$891,433
Activation All Other	2,048	$174,318
Total	2,048	$1,065,751
Projected Availability:		
Activation All Other Oct 94-Sept 95		$174,318
Capital Investment Oct 94-Sept 95		$240,433
Capital Investment Aug 95-Sept 96		$651,000
Total		$1,065,751

Data Source: FY 1995 Medical Care Budget

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ATTACHMENT A

FISCAL YEAR 1995 ACTIVATIONS					
		FTE	TOT REC (000's)	NON REC (000's)	TOTAL (000's)
REPLACEMENT/MODERNIZATION	NEW	1,095.6	$68,894	$61,235	$130,129
REPLACEMENT/MODERNIZATION	ANN'L	137.4	$9,209	$335	$9,544
SUBTOTAL		1,233.0	$78,103	$61,570	$139,673
GENERAL	NEW	90.5	$5,134	$24,486	$29,620
GENERAL	ANN'L	61.3	$4,995	$373	$5,368
SUBTOTAL		151.8	$10,129	$24,859	$34,988
OUTPATIENT IMPROVEMENT	NEW	8.0	$448	$9,103	$9,551
SATELLITE OPC	NEW	139.5	$8,398	$5,033	$13,431
SATELLITE OPC	ANN'L	30.0	$2,084	$3,439	$5,523
SUBTOTAL		177.5	$10,930	$17,575	$28,505
NHCU	NEW	659.5	$39,028	$17,285	$56,313
NHCU	ANN'L	79.0	$4,123	$2,077	$6,200
SUBTOTAL		738.5	$43,151	$19,362	$62,513
DOMICILIARY	NEW	0.0	$0	$3,376	$3,376
DOMICILIARY	ANN'L	7.0	$432	$5	$437
SUBTOTAL		7.0	$432	$3,381	$3,813
CLININCAL IMPROVEMENT	NEW	122.5	$9,243	$25,222	$34,465
CLININCAL IMPROVEMENT	ANN'L	30.6	$2,490	$6,201	$8,691
ELECTRICAL	ANN'L	5.0	$199	$0	$199
FIRE AND SAFETY	NEW	1.0	$104	$27	$131
FIRE AND SAFETY	ANN'L	0.0	$20	$0	$20
MINOR MISC	NEW	56.5	$2,752	$7,407	$10,159
MINOR MISC	ANN'L	13.5	$763	$469	$1,232
NRM	NEW	56.0	$3,534	$30,869	$34,403
RESEARCH/EDUCATION	NEW	7.0	$1,860	$3,070	$4,930
SEISMIC	NEW	0.0	$4	$7,924	$7,928
RESTORED FY94 SLIPPAGE		91.1	$5,797	$12,691	$18,488
SUBTOTAL		383.2	$26,766	$93,880	$120,646
FY95 SLIPPAGE		(643.0)	($38,580)	($16,884)	($55,464)
GRAND TOTAL		2,048.0	$130,931	$203,743	$334,674
ESTIMATED SAVINGS (25%)		512.0	$32,733	$50,967	$83,700

CORPORATE OVERHEAD

ATTACHMENT B

(Data Source: FY 94 VACO Budget Call)

ENTRALIZED ACCOUNTS

ymbol	Program	FTE 95	FTE 96/97	Short Term FY95	Mid Term FY96	Mid Term FY97	Total	Recommendation
17	TQI				$199,600		$199,600	PHASE OUT SPECIAL VACO FUNDING IN FY95
10	DISTINGUISHED PHYSICIAN PROGRAM	4.6	19.2	$374,537	$749,074	$749,074	$1,872,685	PHASE-OUT OVER 3 YEARS 20%/40%/40%
15	AHCPR SHARING AGREEMENT			$170,000			$170,000	PHASE-OUT FY94
15	PATIENT SATISFACTION SURVEY			$39,600			$39,600	PHASE-OUT FY94
17	DMMS/OSS		80.0	$7,014,000			$7,014,000	PHASE-OUT FY94
8	RESIDENT ENGINEERS PROGRAM	13.0	117.0	$977,000	$1,955,400	$6,840,738	$9,773,138	PHASE-OUT 3 YEARS 10%/20%/70% & MAKE PART OF C.I./INSTRUCTION CONTRACT
16	RECRUITMENT RETENTION	135.0		$2,835,451			$2,835,451	REDUCE 25% IN FY95/EVALUATE FUTURE NEED
17	VACO ACCOUNTS/CONTRACTS			$2,730,603	$2,730,604	$2,730,604	$8,191,811	REDUCE 7.5% OVER THREE YEARS
	Total Centralized Accounts	152.6	216.2	$14,141,191	$5,634,678	$10,320,416	$30,096,285	

ATIONAL FIELD UNITS

ymbol	Program	FTE 95	FTE 96/97	Short Term FY95	Mid Term FY96	Mid Term FY97	Total	Recommendation
11	CLINICAL INDICATOR PROJECT		1.7		$78,359		$78,359	PHASE-OUT FY94/95
11	NAT CTR CLINICAL ETHICS -WFU		5.0		$296,200		$296,200	PHASE-OUT FY94/95
11	L-T PSYCH EVALUATION COMPNT		7.0		$432,500		$432,500	REQUEST FINAL REPORT PHASE-OUT FY94/95
11	ROTATING PHARMACISTS		2.0		$243,899		$243,899	PHASE-OUT FY94/95
11	MOBILE CLINIC EVALUATION		5.0		$170,400		$170,400	PHASE-OUT FY94/95 BASED ON EVALUATION
11	DECENTRAL VA/UNIV PROF IN ASPS		1.0		$92,024		$92,024	PHASE-OUT FY94/95
13	NATIONAL ENGINEERING SVC CTR		14.0		$976,963		$976,963	PHASE-OUT FY94/95
15	10A 15 QA/QM INSTITUTE		24.0		$2,719,456		$2,719,456	PHASE-OUT FY94/95
15	RISK MGT INFO SYSTEM		1.0		$45,000		$45,000	PHASE-OUT FY94/95
16	CDS CENTRAL INFO CENTER		2.0		$59,199		$59,199	PHASE-OUT FY94/95
16	MEDICAL INFORMATION SECURITY		8.0		$530,986		$530,986	PHASE-OUT FY94/95
17	PLANNING SYS SUPPORT-GAINESVILLE		6.0		$291,883		$291,883	PHASE-OUT FY94/95
17	MGT ENGR SVC - HOUSTON		7.0		$342,425		$342,425	PHASE-OUT FY94/95
17	FDP DATA BASE/FAC PLAN SYS		3.0		$189,000		$189,000	PHASE-OUT FY94/95
11	PROSTHETIC DHCP REMOTE DEVELOP		3.0			$123,975	$123,975	PHASE-OUT FY95/96
11	NORTHEAST PROG EVAL CTR		12.0		$778,731		$778,731	REDUCE 50%
11	CFECCS		110.0		$9,300,000		$9,300,000	REDUCE 50%
13	REGIONAL DIRECTOR'S OFFICE		252.0		$17,926,702		$17,926,702	VSA RECRO FY95
16	INFORMATION SYSTEMS CENTERS	55.3	165.7	$7,053,427	$4,232,056	$2,821,371	$14,106,854	REDUCE 50% OVER 3 YEARS (25%/15%/10%) / REORGANIZE
16	HC STAFF DEVELOP/RETENTION FLD		2.0		$107,400		$107,400	REDUCE 25%
17	BOSTON DEVELOPMENT CENTER		11.0		$867,673		$867,673	REDUCE 25%
10	EMERG PREPAREDNESS		48.0		$1,307,863	$1,307,863	$2,615,726	REDUCE 50% OVER 2 YEARS (25%/25%) / REORGANIZ
	Total National Field Units	55.3	698.4	$7,053,427	$40,988,712	$4,253,209	$52,293,348	

CORPORATE OVERHEAD

ATTACHMENT B

(Data Source: FY 94 VACO Budget Call)

NATIONAL PROGRAM OFFICES

Symbol	Program	FTE 96	FTE 96/97	Short Term FY95	Mid Term FY96	Mid Term FY97	Total	Recommendation
11	NATIONAL VHA ANESTHESIA SVC	4.0		$286,621			$286,621	DECENTRALIZE FUNCTION/ELIMINATE PROGRAM (DO NOT ACTIVATE)
11	INFECTIOUS DISEASES - VACO		2.0		$88,000		$88,000	DECENTRALIZE FUNCTION/ELIMINATE PROGRAM
11	CHF TREATMENT SERVICES		2.0		$185,000		$185,000	DECENTRALIZE FUNCTION/ELIMINATE PROGRAM
11	DECENTRALIZED RAD SVC-DURHAM		5.0		$351,287		$351,287	DECENTRALIZE FUNCTION/ELIMINATE PROGRAM
11	NUCLEAR MED SVC ANN ARBOR		6.3		$510,796		$510,796	DECENTRALIZE FUNCTION/ELIMINATE PROGRAM
11	NEUROLOGY FIELD UNIT		1.5		$186,414		$186,414	DECENTRALIZE FUNCTION/ELIMINATE PROGRAM
11	NAT VA CHAPLAIN CTR-HAMPTON		17.0		$988,842		$988,842	DECENTRALIZE FUNCTION/ELIMINATE PROGRAM
11	DIR OPTOMETRY SVC-FT HOWARD		2.0		$138,625		$138,625	DECENTRALIZE FUNCTION/ELIMINATE PROGRAM
11	PODIATRIC		2.0		$164,617		$164,617	DECENTRALIZE FUNCTION/ELIMINATE PROGRAM
11	DECENTRALIZED DENTISTS		3.0		$419,704		$419,704	DECENTRALIZE FUNCTION/ELIMINATE PROGRAM
11	RMS-OFFICE OF DIRECTOR		5.0		$487,856		$487,856	DECENTRALIZE FUNCTION/ELIMINATE PROGRAM
11	DECENT AUDIOLOGY/SP PATHOLOGY		2.0		$146,116		$146,116	DECENTRALIZE FUNCTION/ELIMINATE PROGRAM
14	LIBRARY PROGRAM OFFICE		2.0		$86,147		$86,147	DECENTRALIZE FUNCTION/ELIMINATE PROGRAM
14	MEDIA PROGRAM OFFICE		2.0		$91,530		$91,530	DECENTRALIZE FUNCTION/ELIMINATE PROGRAM
	Total National Program Offices	**4.0**	**51.8**	**$286,621**	**$3,824,944**	**$0**	**$4,111,565**	

RESEARCH CENTERS

Symbol	Program	FTE 96	FTE 96/97	Short Term FY95	Mid Term FY96	Mid Term FY97	Total	Recommendation
12	ALCOHOL RESEARCH CENTER		3.0			$326,548	$326,548	PHASE-OUT FY95/96
12	SCHIZOPHRENIA RESEARCH CENTER		3.0			$419,015	$419,015	PHASE-OUT FY95/96
12	AIDS RESEARCH CENTER		5.5			$797,097	$797,097	PHASE-OUT FY95/96
	Total Research Support		**11.5**	**$0**	**$0**	**$1,542,660**	**$1,542,660**	

CORPORATE OVERHEAD

(Data Source: FY 94 VACO Budget Call)

NATIONAL TRAINING PROGRAMS				Short Term	Mid Term			
Symbol	Program	FTE 95	FTE 96/97	FY95	FY96	FY97	Total	Recommendation
10	HOMDEC		29.0		$6,737,544		$6,737,544	PHASE-OUT FY94/95
11	GRAD DENTAL GERIATRIC FELLOWS		6.0		$314,624		$314,624	PHASE-OUT FY94/95
13	ENG TRAINING CENTER		15.5			$1,396,011	$1,396,011	PHASE-OUT FY95/96 BECOME SELF SUSTAINING
14	TUITION SUPPORT							
14	VALOR							
14	NATIONAL TRAINING PROGRAM							
14	SENIOR MANAGEMENT CONFERENCE							
14	INSTITUCTIONAL SUPPORT							
14	CEPU							
14	LEARNING RESOURCE CENTER							
14	AIDS INFORMATION CENTER							
	SUBTOTAL AsCMD ACADEMIC AFFAIRS	100.0		$10,389,249			$10,389,249	INTERFACE THE ACADEMIC AFFAIRS ACCOUNTS PERFORM AND EVALUATE
	Total National Training Program	100.0	50.5	$10,389,249	$7,052,168	$1,396,011	$18,837,428	
	GRAND TOTAL	312.1	1,028.4	$31,870,488	$57,496,502	$17,512,295	$106,881,286	

OTHER PROGRAMS FOR REVIEW		
7	VA LAW ENFORCEMNT TRAINING CTR	FURTHER REVIEW AND EVALUATION
11	INDEPENDEND LIVING (IL) PROG	FURTHER REVIEW AND EVALUATION
13	VA NAT TELECONFERENCING SYS	FURTHER REVIEW AND EVALUATION
11	NAT HEARING AID PROGRAM	FURTHER REVIEW AND EVALUATION
13	CONTRACT SERVICE CENTER	FURTHER REVIEW AND EVALUATION
11	GERIATRIC EVAL & MGT PROG	FURTHER REVIEW AND EVALUATION
11	PTSD ACCOUNTS	FURTHER REVIEW AND EVALUATION
11	SUBSTANCE ABUSE ACCOUNTS	FURTHER REVIEW AND EVALUATION
16	MED CARE PRINTING VACO	FURTHER REVIEW AND EVALUATION

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ATTACHMENT C
Management Reductions/Consolidations

• **Abolishing Assistant Chief positions** - A mid-range estimated salary is calculated for each position, the number of hospitals affected was estimated for each position.

Calculations:

a. Reductions in staffing:

Position(s)	FTE	# Hospitals	Total FTE
Engineering	1.0	150	150
Env. Mgmt.	1.0	100	100
A&MMS	1.0	170	170
Fiscal	1.0	150	150
Personnel	1.0	100	100
MAS	1.0	170	170
Dietetics	1.0	150	150
Pharmacy	1.0	120	120
Security	1.0	60	60
Prosthetics	1.0	20	20
Chaplain	1.0	10	10
Voluntary	1.0	30	30
IRM	1.0	50	50
SWS	1.0	120	120
Psychology	1.0	80	80
TOTAL			1,480

b. Dollar Savings:

Position(s)	Avg Salary	Total FTE	Total Dollars
Engineering	$58,851	150	$8,827,650
Env. Mgmt.	$44,694	100	$4,469,400
A&MMS	$58,851	170	$10,004,670
Fiscal	$58,851	150	$8,827,650
Personnel	$58,851	100	$5,885,100
MAS	$58,851	170	$10,004,670
Dietetics	$58,851	150	$8,827,650
Pharmacy	$69,983	120	$8,397,960
Security	$40,583	60	$2,434,980
Prosthetics	$40,583	20	$811,660
Chaplain	$44,694	10	$446,940
Voluntary	$40,583	30	$1,217,490
IRM	$58,851	50	$2,942,550
SWS	$58,851	120	$7,062,120
Psychology	$58,851	80	$4,708,080
TOTAL		1,480	$84,868,570

Notes: Average Salary calculated from FY 1993 Salary Chart with 3.09% Adjustment, utilizing following Grades/steps: Eng.,A &MMS, Fiscal, Personnel, MAS, Dietetics, IRM, SWS, Psychology - GS 12/5; ENMS, Chaplain - GS 10/5; Security, Prosthetics, Voluntary - GS 9/5. 25% was added for Fringe Benefits.

Prorated 10% Short Term, 70% Mid Term, 20% Long Term

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• **Abolish all Assistant Director/one clerical support position** - Dollars estimated by using mid-range salary of GS-14 and GS-5 positions for 40 hospitals.

Position	Grade	Avg.Sal.	#Hospitals	Dollars	FTE
Asst.Dir	GS14/5	$82,703	40	$3,308,120	40
Secretary	GS 5/5	$26,783	40	$1,071,320	40
Totals				$4,379,440	80

Notes: Average Salary calculated from FY 1993 Salary Chart with 3.09% Adjustment. 25% was added for Fringe Benefits.

• **Readjustment Counseling** - Eliminate Readjustment Counseling overhead. Regional Office staff is known for two Regions (8 each). Since there are seven Regions, the FTE is multiplied by 7 to represent the Regional Offices. Then an additional 9 positions are added to account for VACO positions and possible undercounting. The total FTE (65) is multiplied by the Average Salary of Cost Center 247-Readjustment Counseling, to obtain the dollar savings.

Calculations:

Estimated Overhead FTE X Average Salary for Cost Center 247(Readjustment Counseling) = Dollar Savings

65 X $44,384 = $2,884,939

Prorated 10% Short-Term, 70% Mid-Term, 20% Long-Term

Data Source: FY 1993 CDR Report

• **Recreation Therapy/Voluntary Service** - Eliminate Chief Recreation and secretary positions. It is estimated that 100 Medical Centers could achieve the reduction. This would be a total of 200 FTE. The average salary of Cost Center 246-Recreation Service is multiplied by this number to provide dollar savings.

Calculations:

Estimated 200 FTE X Average Salary for Cost Center 246(Recreation Service) = Dollar Savings

200 X $38,514.84 = $7,702,968

Prorated 10% Short-Term, 70% Mid-Term, 20% Long-Term

Data Source: FY 1993 CDR Report

• **Engineering/Environmental Service (Plant Management Service)** - Savings achieved by eliminating the following positions:

1 Engineering Assistant Chief or 1 Environment Mngt. Service Chief
1 Environment Management Assistant Chief
3 Mid-level Supervisors
2 WG employees
1 Clerical

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Average salaries are computed for each position. Number of hospitals affected is estimated at 100-170.

Calculations:

a. Reductions in staffing:

Position(s)	FTE	# Hospitals	Total FTE
Eng.Asst.Chf.or ENMS Chf.	1.0	150	150
ENMS Asst. Chief	1.0	100	100
Mid-Level Supvr	3.0	170	510
Avg. WG	2.0	150	300
Clerical	1.0	150	150
TOTAL	8.0		1,210

b. Dollar Savings:

Position(s)	Avg Salary	Total FTE	Total Dollars
Eng.Asst.Chf.or ENMS Chf.	$58,851	150	$8,827,650
ENMS Asst. Chief	$44,694	100	$4,469,400
Mid-Level Supvr	$39,679	510	$20,236,290
Avg. WG	$21,261	300	$6,378,300
Clerical	$23,739	150	$3,590,850
TOTAL		1210	$43,502,490

Notes: Average Salary calculated from FY 1993 Salary Chart with 3.09% Adjustment, utilizing following Grades/steps: Eng. Asst. Chf./ENMS Chief-GS 12/5; ENMS Asst. Chf.-GS 10/5; Mid-Level Spvsr.-WG 5/3; Avg. WG-WG 3/2; Clerical-GS 4/5. 25% was added for Fringe Benefits.

Prorated 10% Short-Term, 70% Mid-Term, 20% Long-Term

• **Medical Administration Service (MAS)** - Eliminate several MAS supervisory positions by consolidating MAS functions under other services. This includes Chief MAS, as well as section chiefs for ward administration, ambulatory care, fee service, office operations, and medical information. Savings are estimated on 6 FTE for 100 VAMCs assumed to implement this option.

Reductions in staffing and dollars:

CCName	FTE	Avg. Salary	Total$(ASX100)
285-Ward Admin	100.0	$26,312	$2,631,200
286-Amb Care	100.0	$26,973	$2,697,300
411-Off of Chief	100.0	$38,461	$3,846,100
413-Contract/Fee	100.0	$28,056	$2,805,600
414-Med Recds	100.0	$26,610	$2,661,000
416-Office Ops	100.0	$26,234	$2,623,400
TOTAL	600.0		$17,264,000

Prorated 10% Short Term, 70% Mid Term, 20% Long Term

Data Source: FY 1993 CDR Report

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- **Independent outpatient clinics and domiciliary consolidated with a parent facility.**

  a. Reductions in staffing:

A&MMS	3.0
Fiscal	4.0
Engineering	3.0
MAS	1.0
Personnel	4.0
COS	3.0
Director	4.0
Social Work	1.0
Psychology	1.0
Pharmacy	1.0
TOTAL	25.0

  25 FTE X 5 consolidations = 125 FTE

  125 FTE X $50,000 = $6,250,000

Data Source: CLM830 Report December 1993

- **Two and three division facilities/administrative services:**

  Medical Center Consolidations:

  a. Reductions in staffing requirements due to efficiencies:

A&MMS	5.0
Fiscal	5.0
Engineering	5.0
MAS	10.0
Personnel	5.0
Dietetics	3.0
Pharmacy	3.0
Environmental	4.0
Director	2.0
Security	1.0
Voluntary	1.0
IRM	2.0
Recreation	1.0
TOTAL	47.0

  b. Salary and FTE savings associated with staffing efficiencies:

  47 FTE X 31 Consolidations = 1,457

  1,457 FTE X 50,000 avg. salary = $72,850,000

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Administrative Consolidations:

a. Reduction in staffing requirements due to efficiencies:

A&MMS	5.0
Fiscal	5.0
Engineering	5.0
Personnel	5.0
Environmental	4.0
IRM	2.0
TOTAL	26.0

b. Salary and FTE savings associated with staffing efficiencies:

26.0 FTE X 41 Consolidations = 1,066

1,066 FTE X 50,000 avg. salary = $53,300,000

• **VHA/VBA** - Consolidate administrative functions where VA Regional Offices and VAMCs are located within the same area:

a. Estimated savings utilizing the following formula:

80% of personnel and fiscal FTE and salary costs per VARO based on payperiod 26.

b. Total savings associated with VARO consolidations

FTE:	304 FTE
Dollars:	$10.9 Million

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ATTACHMENT C
VBA/VHA Consolidations
Locations

Albuquerque
Atlanta
Baltimore
Boise
Boston
Buffalo
Chicago
Cleveland
Columbia
Dallas
Denver
Des Moines
Detroit
Hartford/Newington
Houston
Huntington
Indianapolis
Jackson
Lincoln
Little Rock
Los Angeles
Louisville
Manchester
Milwaukee
Minneapolis/Ft. Snelling
Montgomery
Muskogee
Nashville
New Orleans
New York
East Orange/Newark
Philadelphia
Phoenix
Pittsburgh
Portland
Providence
Reno
Roanoke/Salem
Salt Lake City
San Diego
San Francisco
San Juan
Seattle
St. Louis
Tampa/St. Petersburg
Waco
Washington
Winston-Salem/Salisbury

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ATTACHMENT D
Program/Service Reductions

- **Beneficiary Travel** - Data Source: FY 1995 budget

- **Patient Clothing** - Elimination of routine pajamas, robes, and slippers. Savings estimates are based on 90% of the national annual replenishment cost of pajamas and robes for FY 1992. Ten percent of the cost will be retained to accommodate indigent patients.

Calculation:

FY 1992 National Annual Replenishment cost X 90% = Savings

$4,100,000 X .9 = $3,690,000

Data Source for FY 1992 replenishment cost: Textile Services, VACO

- **Employee Uniforms** - FTE of 136 based on assumption that 80% of VAMCs will reduce 1 FTE. Cost includes the personal service dollars associated with these FTE (based on average salary of Cost Center for Laundry) plus the uniform issue cost and uniform allowance at one medical center extrapolated to 170 medical centers.

FTE Calculation:

It is determined that for one medical center (Albuquerque) approximately 1 laundry FTE is devoted to uniform care. This is based on the pounds of laundry associated with uniforms.

Medical Center Uniform Pounds / Medical Center Total Pounds = % devoted to Uniforms

450 lbs. / 8,500 lbs. =5.3%

This percentage is applied to the medical center's laundry FTE to estimate the FTE savings for the medical center.

Medical Center Laundry FTE X Percentage of Uniform Pounds = FTE savings.

18.0 X .053 = .95 FTE

This FTE number is rounded to 1 FTE. It was then estimated that 80% (136) of the 170 medical centers will be able to acieve this reduction.

1.0 FTE X 136 Medical Centers = 136.0 FTE

Calculation of Dollars:

An average salary of $25,491 (which includes fringes) is used to calculate the dollar savings associated with this FTE reduction:

$25,491.25 (Av.Slry.) X 1.0 FTE X 136 Medical Centers = $3,466,810

The Uniform Allowance analysis account expenditures for one pay period at one medical center (Alburqueque) is multiplied by 26 pay-periods to calculate expenditures for the year.

$1,315 (UA expenditure for PP26) X 26 pay periods = $34,190

Uniform issuance costs for the medical center are also calculated. This calculation is done by identifying the number of employees issued uniforms (780) and identifying the annual number of uniforms each (5 per employee). The total number of uniforms (5 X 780 = 3,900) are costed at $15 each to arive at the annual cost.

3,900 uniforms X $15 each = $58,500

The cost of issuance is added to the cost of Uniform Allowance. This total is multiplied by 80% to deflate the estimate to the average medical center. This number is multiplied by 170 medical centers to obtain the dollar savings.

$34,190 + $58,500 = $92,690

$92,690 X .8 = $74,152

$74,152 X 170 Medical Centers = $12,605,840

This cost is added to the personal service dollar cost to arrive at total dollar savings:

$12,605,840 + $3,466,810 = $16,072,650

- **Dialysis** - Eliminate chronic dialysis programs and shift workload to Medicare. Keep acute dialysis where needed Numbers estimated by removing 25% of the dollars and FTE in cost center 211-Dialysis.

Calculations:

FY 1993 Total FTE for Cost Center 211(Dialysis) X 25% = FTE Savings

496.9 X .25 = 124

FY 1993 Total Dollars for Cost Center 211(Dialysis) X 25% = Dollar Savings

$49,965,568 X .25 = $12,491,392

Prorated 10% Short-Term, 70% Mid-Term, 20% Long-Term

Data Source: FY 1993 CDR Report

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• **Fire Protection Service** - Reduction achieved by cutting FY 1993 FTE and total dollars for cost center 532-Fire Protection Unit by 50%.

Calculations:

FY 1993 Total FTE for Cost Center 532(Fire Protection Unit) X 50% = FTE Savings

454.3 X .5 = 227

FY 1993 Total Dollars for Cost Center 532(Fire Protection Unit) X 50% = Dollar Savings

$17,600,878 X .5 = $8,800,439
Prorated 10% Short-Term, 70% Mid-Term, 20% Long-Term

Data Source: FY 1993 CDR Report

• **Chaplain Service** - This proposal would provide for one Chaplain Coordinator, and one program assistant for each medical center.

To be Retained:

Position	Grade	Avg.Sal.	#Hospitals	Dollars	FTE
Chaplain	GS12/5	$58,851	170	$10,004,670	170
Prog.Asst	GS 5/5	$26,783	170	$1,071,320	170
Totals				$14,557,780	340

Total Chaplain Service VA Wide:	PS$	$34,364,643	670.2
Difference (Savings)		$19,806,862	330.2

Notes: Average Salary calculated from FY 1993 Salary Chart with 3.09% Adjustment. 25% was added for Fringe Benefits.

Prorated 10% Short-Term, 70% Mid-Term, 20% Long-Term

ATTACHMENT I
FTE Reduction-Contract

Cost Centers					10.00%		10.00%	70.00%		70.00%	20.00%		20.00%	100%	
			Category		FY 95			FY 96 97			FY 98 - Beyond			Grand Total	
Cost Center	FY93 TOTS	FY93 FTE			FTE	Tot $		FTE	Tot $		FTE	Tot $		FTE	Tot $
National	$1,426,611,290	33,501.4			3,954	$0		11,214	$0		3,193	$0		18,371	$0
215 MEDICAL	$20,347,173	434.3	Contract15%		22	$0		152	$0		43	$0		217	$0
243 DIETETIC	$473,816,856	11,460.30	Contract15%		504	$0		3,525	$0		1,007	$0		5,036	$0
248 DENTAL	$165,400,314	3,734.30	Contract15%		136	$0		964	$0		273	$0		1,363	$0
407 SECURITY	$87,956,366	2,340.30	Contract15%		117	$0		819	$0		234	$0		1,170	$0
570 LAUNDRY	$49,435,433	1,490.10	Contract15%		75	$0		522	$0		149	$0		746	$0
561 OFF OF CH.	$29,102,313	656.5	Contract0%		33	$0		230	$0		66	$0		328	$0
562 PEST	$4,257,601	96	Contract0%		5	$0		33	$0		9	$0		45	$0
563 GROUNDS	$3,483,548	77.7	Contract0%		4	$0		27	$0		8	$0		39	$0
564 SANITATION	$393,849,895	9,645.10	Contract0%		482	$0		3,376	$0		965	$0		4,823	$0
565 BED SVC &	$14,474,010	364.1	Contract0%		25	$0		197	$0		55	$0		282	$0
567 WASTE	$11,565,385	121.6	Contract0%		6	$0		41	$0		12	$0		61	$0
571 LINEN	$31,899,773	762.8	Contract0%		38	$0		267	$0		76	$0		381	$0
575 INTERIOR	$67,107,244	312.9	Contract0%		16	$0		110	$0		31	$0		156	$0
Environmental	$475,839,736	12,230.8	Contract15%		612	$0		4,281	$0		1,223	$0		6,116	$0
			Contract Allocation		7	$0		52	$0		15	$0		74	$0
Transplants			Disbursement Interest		2,351	$0		0	$0		0	$0		2,351	$0
Residents			Reduction/Contract(10%)		130	$7,372,554		909	$49,565,790		260	$14,144,511		1,299	$70,722,85
127 PSYCHOLOG	$153,744,690	2,851.20													

DATA SOURCE: FY93 CDR

NOTE 1: DIETITIANS (1,398 FTE SUBACCOUNT 1619) EXCLUDED FROM DIETARY ADJUSTMENT

NOTE 2: ALTHOUGH DOLLARS ARE SHOWN FOR PSYCHOLOGY, ACTUAL ACTION WOULD BE COMBINATION OF CONTRACT AND RETENTION

NOTE 3: PSYCHOLOGY FTE REDUCTION SET AT 46% TO AVOID DUPLICATION OF MENTAL HEALTH SERVICE RECOMMENDATION

NOTE 4: RESIDENTS FROM 1995 CONGRESSIONAL SUBMISSION ACTUAL 1993 NUMBERS
CLASSIFICATIONS: PHYSICIAN RESIDENTS(2,866), SPECIALIZED (BELOW 3115), DENTAL, RESIDENTS(121), OPTOMETRY, PODIATRY, RESIDENTS
TOTAL REDUCTION TO BE ACHIEVED IN FY95 THROUGH DISCLOSURE AGREEMENTS

NOTE 5: ALL OTHER CALCULATIONS REPRESENT 30% OF TOTAL FY93 FTE. PRORATION IS 10% SHORT TERM, 70% MIDTERM, 20% LONG TERM

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ATTACHMENT E
Contracting

Transplant Centers
(Estimated FTE)

VAMC	Transplant Program	FTE
Salt Lake City	Heart	29.0
Richmond	Heart, Lung	34.5
Hines	Heart	9.7
Pittsburg, U.D.	Liver	43.4
Portland	Liver	29.0
Boston	Kidney	11.4
Tucson	Kidney	16.6
TOTAL		173.6

Data Sources:
FTE for Salt lake City, Richmond, Hines, Pittsburgh U.D., and Portland based on FY 1992 for fix team cost.
FTE for Boston and Tucson's Kidney Transplant Program is taken from FY 1993 CDR.

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ATTACHMENT F
VSA Initiatives

- **Surgical Realignment**

Region 1	FTE	Dollars	ADC
Altoona	47.0	$ 3,141,294	13
Clarksburg	69.0	4,861,581	20
Erie	42.0	2,552,141	15
Lebanon	48.0	3,278,981	11
Manchester	56.0	4,017,651	13
TOTAL	262.0	$17,851,648	72

Region 2	FTE	Dollars	ADC
Danville	56.0	3,471,582	19
Ft. Meade	61.0	4,037,793	13
Ft. Wayne	38.0	2,455,992	11
Hot Springs	21.0	1,400,540	6
Iron Mountain	19.0	1,292,069	6
Poplar Bluff	29.0	1,821,339	10
Saginaw	28.0	1,754,282	9
Topeka	48.0	2,864,310	12
Leavenworth	44.0	3,613,510	11
TOTAL	344.0	$22,711,417	97

Region 3	FTE	Dollars	ADC
Big Springs	36.0	$ 2,725,068	16
Dublin	37.0	2,374,656	13
Fayetteville (AR)	29.0	1,876,489	10
Kerrville	19.0	1,408,699	8
Tuskegee	55.0	3,727,337	12
TOTAL	176.0	$12,112,249	59

Region 4	FTE	Dollars	ADC
Ft. Harrison	36.0	$ 2,552,859	10
Cheyenne	30.0	2,314,830	8
Boise	58.0	4,514,006	10
Grand Junction	36.0	2,839,578	14
Miles City	13.0	792,437	4
Roseburg	45.0	2,480,769	15
Spokane	40.0	2,933,326	13
Walla Walla	22.0	1,415,088	4
TOTAL	280.0	$19,842,893	78

GRAND TOTAL	1,062.0	$72,518,207	306

26% of the Total Costs, which is A/O, will go to those stations whose patients would be referred for surgery = $19,942,000.

Savings = ($72,518,207-$19,942,000) or $52,576,207

Data Source: FY 1993 CDR Report

PRE-DECISIONAL

• **Mental Health and Behavioral Science Service** - Consolidate existing services for Mental Health into one service, thereby eliminating one chief position. Services concerned are primarily Psychiatry and Psychology. Social Work should also participate in the reorganization.

Estimated Savings	FTE	Funds
Short-term	10.0	$529,618
Mid-term	70.0	$3,707,325
Long-term	20.0	$1,059,236
Total	100.0	$5,296,179

Methodology: Numbers estimated by assuming change will affect 100 Medical Centers. Average salary of CDR cost center 227-Psychology for FY 1993 is used to calculate dollars (Average salary CC 227 * 100). Average Salary rather than Chief salary is used to better approximate actual savings.

Data Source: FY 1993 CDR

• **Business Service** - Consolidate Fiscal and OA&MM.

Methodology: Assumes 2 FTE saved at approximately 30 medical centers at an average salary of $40,000. 30 facilities are used to reduce potential duplication when consolidating medical centers and eliminating assistant service chiefs.

• **Workload Realignment/Mission Changes** - Workload Realignment Report Survey dated May 1, 1992.

Mr. HINCHEY. So the report, then, is 4 to 5 years old? It was done 4 or 5 years ago?

Mr. FARSETTA. Yes.

Mr. HINCHEY. OK. Again, I want that report to be available, not just to myself but to other members of the committee. I think it's important for us to look at it so that we can see what has been driving these actions and we could correlate the thinking that went on that occasioned some of the things that have been taking place within the VA. I think that's important.

I mentioned the clinics. And I congratulate you on that. I fully support what you're doing in that regard. I think that is going to be helpful. And I think it will improve the quality of care.

I also would make the observation, however, that it is not the outpatient care that is of particular concern. It seems to me based upon my observation that most people are fairly satisfied with the quality of care that is being delivered on an outpatient basis. That's the quality of care which would come from these clinics.

[Chorus of boos.]

Mr. HINCHEY. That may not be the case. [Laughter.] [Applause.]

So far as the information that has come to our attention, it is primarily the inpatient care——

Audience PARTICIPANT. That's right.

Mr. HINCHEY [continuing]. That is really at the larger part of the issue. So I think that while the clinics are going to be helpful—and I fully believe that that does not reduce the need for our commitment to assure that the quality of care internally continues to be good.

Mr. FARSETTA. I agree.

Mr. HINCHEY. Now, as I understand it, your intention is to contract out for the care of these clinics. Is my understanding correct about that?

Mr. FARSETTA. No. I think that we are going to be joint venturing with Network No. 2 in the Kingston clinic. And the model that they use is they do some contracting out for their community care, their outpatient care. And we're going to pilot with them. In some of the other clinics in Network No. 3, we have not gone to the contract model. We have used a staff model.

There are some individuals, some veterans, who seem to like the contract model. We're going to try the contract model and see how it works and whether the veterans like it or not.

Mr. HINCHEY. I'm also aware of—you mentioned a few moments ago—let me put it this way—that there were no further reductions in staff that are being completed. But I know also that you've sent out information recently which talks about buyouts.

Mr. FARSETTA. Yes.

Mr. HINCHEY. Now, as a result of those buyouts, there will be a reduction in personnel at both hospitals. I think the number ultimately is something in the neighborhood of 28.

Now, you were obviously considering that when you said that there would be no further reduction. So what you're saying is that after these 28 buyouts, there will be no further reductions in personnel contemplated?

Mr. FARSETTA. That's correct.

Mr. HINCHEY. That's correct.

Mr. FARSETTA. I apologize for not factoring that into consideration. And let me raise this and so I can be straight about it, that there are some positions that may be eliminated. OK?

So we may eliminate any administrative position. And that job will not be filled, but then we will substitute someone else into that job in a different area, perhaps in a patient care area. So it is conceivable that 28 folks may leave, but 28 other people may be hired in very different jobs than the people who were in those jobs.

Mr. HINCHEY. Well, that's nice to hear. However, I notice the word "conceivable," and I am not comfortable with the word "conceivable." If you are telling me that when these 28 people leave and in the context of their leaving they will largely support administrative personnel, that you are analyzing this situation in a way that you expect to bring in additional health care personnel to fill those 28 blank positions, then I find some comfort in that. But if you're telling me that it's only conceivable, then I'm not comfortable.

So how likely is it to happen?

Mr. FARSETTA. Since I'm on the road, I don't want to give you a definitive answer, but I will provide that information to you factually.

[The information referred to follows:]

VA Hudson Valley Health Care System
Buyout Plan White Paper

Title: To explain the medical center's buyout strategy.

Discussion: In May 1997, a survey was conducted at both campuses to determine what interest there might be for buyouts as a result of additional slots available in VHA. Approximately 160 employees in the VA Hudson Valley HCS expressed an interest in a buyout. Senior management reviewed this list and arrived at 28 positions which could be abolished. These positions were virtually all administrative, managerial or supervisory. Six employees were given the early buyout (prior to September 30, 1997). These positions and the disposition of the FTEE are as follows:

Position	Campus	Disposition
Director	Castle Point	Reinvest as direct patient care
Chief, Radiology	FDR	Reinvest as direct care physician
Recreation Supervisor	FDR	Reinvest as direct care recreation therapist
Physician	Castle Point	Replace with a direct care physician
Supply Technician	FDR	Reinvest as direct patient care
Administrative Office in Podiatry	FDR	Reinvest as direct patient care podiatrist to Staff clinics

Of the remaining 22 people on the list, 12 have declined the buyout, one position has been withdrawn as it cannot be abolished and one is undetermined. Eight remaining positions are presently firm for the FY1998 buyout. These positions and the intended disposition of the FTEE are as follows:

Position	Campus	Disposition
Supervisory Social Worker	FDR	Reinvest as direct patient care
Librarian	FDR	Reinvest as direct patient care
Staff Engineering	FDR	Reinvest as tradesman
3 Secretarial Positions	FDR	Reinvest as direct patient care
Physician's Asaistant	Castle Point	Replace with a direct care physician Extender
Physician	Castle Point	Replace with a direct care physician

Employees who have declined will be offered a last chance prior to the December 31, 1997, deadline. If others express an interest in the FY1998 buyout, it will be limited to administrative, managerial or supervisory positions which can be abolished.

Mr. HINCHEY. My time is up, and I thank you.

Mr. SHAYS. At this time, Ms. Kelly, you have the floor.

Ms. KELLY OF NEW YORK. Thank you.

Mr. Farsetta, when you and your deputy directors are graded on your annual review, isn't it true that you're graded on the basis of your ability to implement the VA's long-term programming as written in the performance agreement, network director performance measures for the VISNs?

Mr. FARSETTA. That's correct.

Ms. KELLY OF NEW YORK. Are not four out of five incentive measures in your performance agreement based on fiscal, rather than patient care standards?

Mr. FARSETTA. No. Nancy, you may want to speak to that.

Ms. KELLY OF NEW YORK. I have that right here in front of me, and it looks that way to me. [Applause.]

Ms. WILSON. That is not true.

Mr. FARSETTA. That's not true.

Mr. SHAYS. Excuse me. I need you just to repeat whatever answer because we are transcribing this, and I just need to make sure your responses are clear. I'm sorry. Dr. Wilson.

Ms. WILSON. They are not fiscal. Four out of five of the performance measures are not fiscally driven.

Ms. KELLY OF NEW YORK. How do you account for that when they're talking about incentive measures as being patient satisfaction is the last one listed, bed days of care per patient—that means cutting them—insufficiency in C&P exams? These are things listed as incentive measures—the ambulatory surgery, primary care enrollment—these are things listed as incentive measures.

Ms. WILSON. I would like to speak to that. The patient satisfaction measure is one of the first times in the history of health care that administrators——

Ms. KELLY OF NEW YORK. Let's deal with the rest of them because that's the last one.

Ms. WILSON. There is no order to them in terms of the listing that you have. Patient satisfaction is very definitely an outcome measure that is a quality outcome measure. And this is one of the first times in health care that administrators are held accountable for their very livelihood based on patient satisfaction scores.

The chronic disease index is a measure of how well we do things like get eye exams for our diabetics, how well we assess their sensation in their feet, how well we check their pulses, whether or not we measure blood tests for them. Our ischemic heart disease measures relate to whether or not patients who have had a heart attack get aspirin or beta blockers, a medication that has been shown to save lives, how well we monitor their cholesterol management. Our obesity measures relate to giving counseling for weight and exercise. Our hypertension measures relate to——

Ms. KELLY OF NEW YORK. I'm sorry, but you're listing things. What I'm looking at is this incentive measures, where, in fact, I'm talking about in the top part of this agreement, it says, "categorized by specific mission goals."

Ms. WILSON. I think that you have a document that is old.

Ms. KELLY OF NEW YORK. I have a document that is from the VA.

Ms. WILSON. I wrote the 1997 performance measures agreement, and I can submit for the record every measure that is in there. I'm intimately familiar with them.

Ms. KELLY OF NEW YORK. This document is 4–17–96. Has this been rewritten?

Ms. WILSON. It has been rewritten.

Ms. KELLY OF NEW YORK. This is the latest one that Dr. Kizer's office was able to supply us.

Ms. WILSON. I will be happy to submit the 1997 performance agreements, where the majority of the measures are quality-driven.

Ms. KELLY OF NEW YORK. Dr. Kizer said this was the latest one.

Mr. SHAYS. Would the gentle lady yield?

Ms. WILSON. It's a mistake.

Mr. SHAYS. Just for the record of the committee——

Audience PARTICIPANT. Dr. Kizer comes up with——

Mr. SHAYS. Excuse me. Excuse me, sir. Just for the record, just because we need to make sure we're clear on this, the document that Ms. Kelly asked you, the document that preceded the one that you worked on, was that the operative document?

Ms. WILSON. That was the operative document between May 1996 and October 1, 1996. The operative document for fiscal year 1997 is the one that you must not have. We were able to implement a number of quality indicators that were quantitative in the fiscal year 1997.

In the fiscal year 1996, the quality indicators were instituting telephone triage, admission and discharge planning. There are a number of things on there.

Mr. SHAYS. Dr. Wilson, let me just be really clear on this just because it would be in terms of candidness. When you were responding to a question, it sounded to me like this wasn't a document that had been adhered to by the VA. I just need to know what——

Ms. WILSON. Oh, it was.

Mr. SHAYS. In the document that she's referring to that preceded the reform, was this the way an individual was graded? Were those——

Ms. WILSON. This was the way. This document represents how the network directors were graded between May and October 1996.

Mr. SHAYS. So the candid answer would have been, "This was the document used, but we have changed it?"

Ms. WILSON. That would be the candid answer, but the other part of that answer would be that there are more quality indicators than financial indicators in that 1996 document.

Mr. SHAYS. OK. Can we just take the 1996 document and just——

Ms. WILSON. Yes.

Mr. SHAYS. If you would just tell us what is different? And I would give back the floor to the gentle lady, who really controls the time here. She had five items. And I just need to know. You don't seem to have that document in front of you, but are they—is this the only document you have?

Ms. KELLY OF NEW YORK. I have another copy.

Mr. SHAYS. You have another copy? Could you just tell us if that document represented a complete evaluation or what would have been left out of it?

This was given to you by Dr. Kizer?

Ms. KELLY OF NEW YORK. It was given to me from two different VA sources: Dr. Hogan and Dr. Kizer. And they said that this was current.

Ms. WILSON. If I may read the first sentence, "The following measures have been chosen for inclusion in the network director's May to September 1996 performance agreements."

Mr. SHAYS. And in that, what are the items, just in that——

Ms. WILSON. "Hire your key personnel; write a strategic plan; implement telephone liaison programs at all facilities; a temporary lodging program; institute a system where people have beds available that don't need to be admitted to the acute care wards but are traveling long distance for outpatient procedures; admission and discharge planning programs; utilization review programs; clinical guidelines; functional assessment of spinal cord injury patients; not delaying prosthetic orders; primary care enrollment," which is the veteran saying there's somebody in charge of their care; "ambulatory surgery, which is a financial utilization measure; insufficient C&P exams" means that when the veteran comes for a C&P exam, a comp and pen exam, it's done adequate the first time. "Bed days of care" is a financial utilization measure.

Mr. SHAYS. Does this represent—I appreciate the gentle lady yielding me back her time for a second. Does this represent what new mandates in addition to other mandates that exist or is this the total in which a supervisor is going to be evaluated?

Ms. WILSON. This is part C of an overall performance plan, where there is a part A and a part B as well.

Mr. SHAYS. Thank you.

Ms. KELLY OF NEW YORK. Thank you very much.

I have two more questions, Mr. Chairman. Is that all right?

Mr. SHAYS. Sure.

Ms. KELLY OF NEW YORK. OK. Mr. Farsetta, to date how many millions of dollars have you taken out of the Castle Point-Montrose system according to the implementation of VERA?

Mr. FARSETTA. I would say in the vicinity as if one looks at 1996 to 1997——

Ms. KELLY OF NEW YORK. A full fiscal year if you can give me that, please.

Mr. FARSETTA. A total of about $4 million.

Ms. KELLY OF NEW YORK. About $4 million?

Mr. FARSETTA. Yes.

Ms. KELLY OF NEW YORK. And we are due to have a total reduction of about $149 million. Is that correct?

Mr. FARSETTA. $148 million under the VERA model.

Ms. KELLY OF NEW YORK. $148 million under the VERA model?

Mr. FARSETTA. But that's for the entire network. That is just not for the two hospitals.

Ms. KELLY OF NEW YORK. OK. For the VERA network?

Mr. FARSETTA. For the network.

Ms. KELLY OF NEW YORK. Which you are in charge of.

Mr. FARSETTA. That's correct.

Ms. KELLY OF NEW YORK. Is that not correct?

Mr. FARSETTA. That's correct.

Ms. KELLY OF NEW YORK. You are in charge of the entire VISN?

Mr. FARSETTA. That is correct.

Ms. KELLY OF NEW YORK. Now, according to this performance agreement——

Mr. FARSETTA. Right.

Ms. KELLY OF NEW YORK [continuing]. The incentive measures that are incorporated in this agreement, from what I understand from this, you will receive a bonus for cutting the full $149 million from our network when you achieve the reduced patient care incentive measures as your direction agreement.

[Chorus of boos.]

Mr. FARSETTA. I think that I'm not going to respond to that. I'll let Nancy respond to that since Nancy is the one who authored that. And it really is much greater than just cutting the dollars.

Ms. KELLY OF NEW YORK. Is it or is it not——

Mr. FARSETTA. I could cut the dollars and lose my job.

Ms. KELLY OF NEW YORK. Is it or——

Mr. SHAYS. Excuse me. The gentle lady will suspend. Believe it or not, we do want to hear what the witness is saying. And I just plead with you. As veterans, I plead with you to show respect to individuals whom you may—I plead with you to show respect as veterans to people who are testifying to this committee.

Dr. Wilson, if you would respond to that question? And would you ask the question again?

Ms. KELLY OF NEW YORK. All right. I'd like, really, Mr. Farsetta's answer if I could get it before——

Mr. SHAYS. Well, Dr. Wilson——

Ms. KELLY OF NEW YORK [continuing]. Dr. Wilson, but it's my understanding, Mr. Farsetta, that you will receive a bonus for cutting the full $149 million from our network based on achieving the reduced patient care incentive measures as per your directions agreement.

Mr. FARSETTA. Not true.

Ms. KELLY OF NEW YORK. Well, that's what it says in the——

Mr. FARSETTA. Not true.

Mr. SHAYS. Dr. Wilson.

Ms. WILSON. I concur with Mr. Farsetta. The performance measures in the 1997 agreement are a list of measures, some of which address utilization and as a proxy for cost. But all the other measures are quality measures.

And it is the composite performance on the performance agreements that makes up the majority of the rating that the network director achieves in that timeframe.

Ms. KELLY OF NEW YORK. I want to quote to you from a General Accounting Office testimony that was in front of the Senate Subcommittee on VA, HUD, and independent agencies, the Committee on Appropriations. This was testimony that was released Thursday, May 1, 1997. On Page 17, it says, "Performance measures and standards developed by headquarters are the key components of VA's monitoring process. Headquarters holds network directors accountable for making progress toward VA goals by including measures and standards of performance in the director's contracts." And it goes on in this report to state that the directors receive a bonus directly due to the amount of money they are able to save in their VISNs.

Now, I need to know whether this is true or not. I think the people in this room are entitled to an answer. [Applause.]

Mr. FARSETTA. That isn't true. We were given an answer. That is not true. It is not true.

Ms. WILSON. It is not true. It is not true. The bonus——

Mr. SHAYS. Excuse me. The lady will suspend. I'm sorry. We cannot hear the witnesses when we hear response from the audience. And I will continually interrupt this hearing until we are able to hear the witnesses. I am going to stay here as long as I have to stay, but I would like this hearing to be conducted in a way we can hear the witnesses.

Dr. Wilson, I apologize for the interruption.

Ms. WILSON. The bonuses are given on the basis of performance on part A, part B, and part C of the performance plan. The measures that we have talked about are part C. There is no measure in the agreement that says you must cut this amount of money.

Mr. GILMAN. Will the gentle lady yield?

Ms. KELLY OF NEW YORK. Yes, I will.

Mr. GILMAN. Dr. Wilson, did Mr. Farsetta receive a bonus for the reductions and the revision of service in our region?

Ms. WILSON. I didn't give him that bonus. So I probably can't officially answer that——

Mr. GILMAN. Well, did the administration give a bonus? Did he receive a bonus?

Ms. WILSON. Yes.

Ms. KELLY OF NEW YORK. And, Mr. Farsetta, it is my understanding that you will continue to receive bonuses for every time that you are able to take the money levels down until we reach that $150 million out of here. Is that correct?

Mr. FARSETTA. No.

Ms. KELLY OF NEW YORK. If not, why not? That's exactly what you said.

Mr. FARSETTA. No, that's not what I said. I think that what Dr. Wilson indicated is that there are three parts to the performance agreement that I have with Dr. Kizer and that I need to demonstrate exceptional performance in all three parts, not in a single entity in one part of the performance agreement. So the bonus is not predicated on the amount of dollars I cut.

Ms. KELLY OF NEW YORK. Remember, I have that agreement in front of me, Mr. Farsetta. We're talking about the amount of primary care enrollment. We're talking about the amount of ambulatory surgery. We have insufficient compensation and pension exams.

Mr. FARSETTA. That has to do with a qualitative standard——

Ms. KELLY OF NEW YORK. That's correct.

Mr. FARSETTA [continuing]. Not a quantitative standard, a qualitative statement on the quality of C&P examinations gave and the amount that was remanded because they were incomplete.

Ms. KELLY OF NEW YORK. The bed days of patient care, it says here, "To be fully successful, the bed days of patient care per patient will decrease in the aggregate of 20 percent. To be considered exceptional," which you just said you wanted to be, they have to decrease in the aggregate by 30 percent.

Now, Dr. Wilson, does that sound familiar to you?

Ms. WILSON. Those were the fully successful and exceptional performance goals in 1996, yes, for decreasing bed days of care across the county.

Ms. KELLY OF NEW YORK. We don't need to go into this any further. I think that I would like to submit some other questions later, but there are a lot of people standing.

But, Mr. Farsetta, I have one last question for you. How much of an incentive bonus did you receive for your reforms?

Mr. FARSETTA. $16,000.

Ms. KELLY OF NEW YORK. $16,000?

Mr. FARSETTA. That's correct.

Ms. KELLY OF NEW YORK. Thank you.

[Chorus of boos.]

Mr. SHAYS. Before I recognize Mr. Hinchey for backup questions, I do want to make sure we make sure the record is accurate. And I just again want to ask this question. As it relates to the performance of any supervisor who is given a bonus, is this one factor?

Dr. Wilson, I just want to make sure that we're really clear because the answer was pretty definitive that the reduction was not a factor in the bonus. Isn't a more accurate response that it would be one of a number of factors that would be utilized in determining a bonus? I just think it's important that both of you be very clear in responding.

And I apologize for the noise that you're receiving because this is important testimony. And I want you to think carefully.

Ms. WILSON. I can speak to the fact that the objective measures in the performance agreement between September and October were part C of a performance plan that had a subjective component as well as the objective performance on these measures. And beyond that, the decision that the Under Secretary makes as far as who gets bonuses would be his. Does that help?

Mr. SHAYS. Well, it helps, but we're going to just pursue it a little bit better here.

I want to encourage people who do a good job to receive a bonus if they're doing a good job. And if they don't do a good job, I obviously don't want them to receive a bonus.

It would strike me logically that there would be many factors for determining who would receive a bonus or not. I'm just a little concerned that the emphatic statement that this was not a factor under oath could be something that would be not something I'm comfortable with.

The issue, it seems to me, is that you would be graded, Mr. Farsetta, on a number of factors, just not part C. I need to know that it does not include that at all, it is not a factor at all, or that it is a factor along with a whole host of other issues. That's the two choices because the way the record stands now, it's not a factor at all.

Ms. WILSON. I would amend my testimony such that the performance plan includes a subjective component. And I cannot testify to all of the elements that are in or out of comprising the Under Secretary's decision about that subjective part. So I would agree with you if that—I would agree with you.

Mr. SHAYS. OK. I'm going to ask it another way, too. Mr. Farsetta, do you agree with that response? No. Don't be——

Mr. FARSETTA. Well, she——

Mr. SHAYS. Yes.

Mr. FARSETTA. Well, the reality is that she's closer to the logic Dr. Kizer uses to evaluate, closer than I am.

Mr. SHAYS. Well, but that——

Mr. FARSETTA. It would be disingenuous of me to suggest that part of financial management wouldn't be part of the consideration for my bonus.

Mr. SHAYS. Would not be? I'm sorry. I missed that. It would be disingenuous what?

Mr. FARSETTA. To think that it wouldn't be part of the consideration.

Mr. SHAYS. Well, you gave a very strong, emphatic answer in the beginning. And basically what I'm suggesting is you are amending your answer.

Mr. FARSETTA. That's correct.

Mr. SHAYS. Not to pull this to the "nth degree" here, but I want to know from you, Dr. Wilson: What does meeting VERA's targets play in the evaluation? Is it 1 percent, 10 percent, 40 percent? Can you get a bonus if you have not met VERA?

Ms. WILSON. I have never had a discussion with the Under Secretary regarding VERA's——

Mr. SHAYS. Let me just——

Ms. WILSON [continuing]. Role in having bonuses. So I don't know the answer to that.

Mr. SHAYS. Well, your response has been amended. We'll follow it up, and staff will followup. I would like a sense of the answer to that question that Ms. Kelly asked.

Mr. Hinchey, you have the floor.

[The information referred to follows:]

1997 NETWORK DIRECTOR PERFORMANCE PLAN

VISN

Introduction
The 1997 Network Directors' Performance Plans consist of Parts A, B, and C. Part A describes network executive core competencies, Part B highlights areas of organizational special concern, and Part C defines quantifiable network performance on a set of measures deemed critical to organizational success.

Evaluation of Part A :
The core competencies are interpersonal effectiveness, customer service, systems thinking, flexibility/adaptability, creative thinking, organizational stewardship, personal mastery, and technical competency. At the end of the rating period, Directors will be asked to briefly describe an action / accomplishment that reflects each of these competencies.

Evaluation of Part B:
The areas of organizational special concern are safety, risk management, credentialing and privileging, and fairness of workforce treatment. At the end of the rating period, Directors will be asked to briefly describe an action / accomplishment that reflects each of these competencies.

Evaluation of Part C:
The performance measures are categorized by the mission goal they support. Within the mission goal of delivering health care value, the measures are further subdivided by domain of value. Each individual measure is equally weighted to maintain maximum network flexibility and to encourage strategic network system thinking.

Summary Rating:
Part A & B parameters must be met to support an overall rating of at least fully successful. Part C is a critical element. The following describes how Parts A, B, and C contribute to the summary rating:

Part A & B	Part C	Summary Rating
Exceptional	Exceptional	Outstanding
Fully Successful	Exceptional	Excellent
Exceptional	Fully Successful	Fully Successful
Fully Successful	Fully Successful	Fully Successful
Less than Fully Successful	Fully Successful	Minimally Satisfactory
Fully Successful	Less than Fully Successful	Unsatisfactory

PART A: CORE COMPETENCIES

I. **Interpersonal Effectiveness:** The ability to build and sustain relationships, resolve conflict, handle negotiation effectively, and develop collaborative working relationships. The successful executive displays empathy, empowers others, and possesses written and oral communication skills.

II. **Customer Service:** The ability to integrate customer service, including patient satisfaction and stakeholder support into a management plan. A customer-driven executive enhances internal and external customer satisfaction. (S/he) models customer service by handling complaints effectively and promptly and ensuring a customer-centered focus in direction and daily work. This executive uses customer feedback in planning and providing products and services and encourages subordinates to meet or exceed customer needs and expectations.

III. **Systems Thinking:** The ability to understand the pieces as a whole and appreciate the consequences of actions on other parts of the system. The successful executive thinks in context, knows how to link actions with others in the organization and demonstrates awareness of process, procedures and outcomes. (S/he) possesses a big (whole) picture view of the world.

IV. **Flexibility/Adaptability:** The ability to quickly adapt to change, handle multiple inputs and tasks simultaneously and accommodate new situations and realities. The successful executive works well with all levels and types of people, welcomes divergent ideas and maximizes limited resources.

V. **Creative Thinking:** The ability to think and act innovatively, look beyond current reality to forecast future direction, take risks, challenge traditional assumptions and solve problems creatively. The successful executive is resourceful.

VI. **Organizational Stewardship:** The successful executive is sensitive to the needs of individuals and the organization and provides service to both. (S/he) assumes accountability for self, others, and the organization. This executive demonstrates commitment to people and empowers and trusts others.

VII. **Personal Mastery:** The ability to recognize personal strengths and weaknesses and to engage in continuous learning and self development. The successful executive demonstrates a willingness to take actions to change, and takes charge of own career.

VIII. **Technical:** The knowledge and skills to perform and evaluate the work of the organization based upon a clear understanding of the processes, procedures, standards, methods, and technologies of the organization. The successful executive demonstrates functional and technical literacy and measures results of work.

PART B: ORGANIZATIONAL SPECIAL CONCERNS

I. **Safety:** Maintain prevention, early detection, and correction systems for accessibility, physical safety, sanitation, and infection control at all facilities

II. **Credentialing and Privileging:** Comply with JCAHO and VHA standards for credentialing and privileging, including procedures for notification of state licensing boards when appropriate

III. **Fair Workforce Treatment:** Render fair and timely decisions in all areas of delegated authority such as EEO complaints, union grievances, and classification appeals

IV. **Risk Management:** VISN management shall conduct a thorough review of both network and facility mechanisms to monitor compliance with implementation and execution of policy guidance and quality improvement efforts for all clinical programs (i.e. medical, nursing, pharmacy, etc.). This shall include a discussion of findings and interventions taken in cases where noncompliance is found and tabulation of policies that are outdated or need revision.

PART C: WORKPLAN

HEALTHCARE VALUE: Domain Of Cost

1. **Bed days of care (BDOC)/1000 unique SSNs**
   By September 30, 1997, fiscal year bed-days of care generated by network VA patients treated by acute care treating specialties at VA or non-VA contract hospitals will be comparable to 1997 projected local Medicare performance for short-stay hospitals.

   Achievement levels
   Fully successful: Match 1997 projected local Medicare performance: xx% reduction to xxxx BDOC/1000 SSN
   Exceptional: 5% fewer BDOC than the local Medicare performance: xx% reduction to xxxx BDOC/1000 SSN

2. **Total operating beds**
   By September 30, 1996, fiscal year total network operating beds will match total network workload requirements.

   Achievement levels
   Fully successful: Total operating beds match 1996 workload: xx% reduction
   Exceptional: Total operating beds match 1997 workload

3. **Ambulatory Surgery**
   By September 30, 1997, the fiscal year percentage of performed HCFA list procedures (CPT codes from HCFA list for surgeries reimbursed in ambulatory care) that are performed in the ambulatory setting will increase.

   Achievement levels
   Fully successful: 65% of HCFA procedures performed will be done on an ambulatory basis.
   Exceptional: 75% HCFA procedures performed will be done on an ambulatory basis.

HEALTHCARE VALUE: Domain Of Access

4. **Category A Users**
   By September 30, 1997, fiscal year Category A veteran users will increase.

   Achievement levels
   Fully successful: 1994-1996 Category A veteran users+.005 1996 Category A veteran population: xxxx users.
   Exceptional: 1994-1996 Category A veteran users+.01 1996 Category A veteran population: xxxx users.

5. **Timeliness of Access**
By September 30, 1997, the average number of Customer Service Standard (CSS) Access problems reported per network patient will meet or exceed the benchmark of .15 (1 problem reported per 6 questions answered).

Achievement levels
Fully successful: Match non-VA benchmark of .15.
Exceptional: Average number of problems reported per patient is .10 (1 problem per 10 questions answered).

HEALTHCARE VALUE: Domain of Technical Quality

6. **Primary Care Enrollment**
By September 30, 1997, the percentage of network primary care patients who answer yes to the question "Is there one provider or team in charge of your care?" on the 1997 ambulatory care customer feedback survey will increase.

Achievement levels
Fully successful: 85%
Exceptional: 90%

7. **Compensation and Pension Requests**
By September 30, 1997, the fiscal year percentage of completed C & P requests reported by VBA as sufficient will be 98%.

Achievement levels
Fully successful: 98% average for 1997.
Exceptional: 99% average for 1997.

8. **Chronic Disease Index**
By September 30, 1997, the network CDI performance will increase.

Achievement levels
Fully Successful: Network CDI will be double the baseline in a snapshot taken August/September 1997.
Exceptional: CDI is 95% in a snapshot taken August/September 1997.

9. **Prevention Index**
By September 30, 1997, the network PI performance will increase.

Achievement levels
Fully Successful: Network CDI will be double the baseline in a snapshot taken August/September 1997.
Exceptional: PI is 95% in a snapshot taken August/September 1997.

10. **Network-wide Clinical Practice Guidelines**
By September 30, 1997, implement 12 nationally developed network-wide clinical practice guidelines, 2 of which are for Special Emphasis populations. Guidelines in place at the end of FY96 are not included in the count.

Fully Successful: 12 new guidelines implemented, 2 of which are for Special Emphasis populations
Exceptional: In addition to the 2 Special Emphasis guidelines, 12 guidelines implemented that cover 12 of the network's 20 high volume common disease entities.

11. **End of Life Planning**
By September 30, 1997, patients with terminal diagnoses or conditions in the final stages of illness, receiving ongoing care through VA, have documentation of an individualized plan for comprehensive, coordinated, end of life care services that minimizes physical and psychological suffering and optimizes the patient's quality of life.

Achievement levels
Fully successful: 95% achievement in 4th quarter 1997.
Exceptional: 99% achievement in 4th quarter 1997.

HEALTHCARE VALUE: Domain of Veteran Satisfaction

12. **Customer Service Standards**
By September 30, 1997, the average number of Customer Service Standard (CSS) problems reported per network patient will meet or exceed the CSS non-VA benchmark performance of .15 (1 problem reported per 6 questions answered).

Achievement levels
Fully successful: Average network performance equals average non-VA benchmark (.15).
Exceptional: Average number of problems reported per patient is .10 (1 problem per 10 questions answered).

13. **Spinal Cord Injury/Dysfunction (SCI/D)Patient Satisfaction**
By September 30, 1996, Spinal Cord Injury/Dysfunction (SCI/D) patients will report their VA care as very good to excellent.

Achievement
Fully successful: 75% report their care as very good or excellent.
Exceptional: 80% report their care as very good or excellent.

HEALTHCARE VALUE: Domain of Functional Status

14. Addiction Severity Index (ASI)
Veterans treated for substance abuse on an inpatient or outpatient basis during September 1997 have at least one ASI on record.

Achievement levels
Fully successful: 90%
Exceptional: 99%

EXCELLENCE IN RESEARCH AND EDUCATION

15. Total Peer-Reviewed Research Funding

Increase 1997 network-level total VA and non-VA peer-reviewed research funding by 5%.

Achievement levels
Fully successful: 2.5% increase for FY 1997 (prorated for 6 months of FY 1997).
Exceptional: 5% increase for FY 1997 (prorated for 6 months of FY 1997).

AN EMPLOYER OF CHOICE

16. Understand Mission and Role in Meeting Mission
By September 30, 1997 employees, when queried, indicate they know the mission of the "new VA" is to improve the health of the served veteran population by providing primary care, specialty care, extended care and related social support services in an integrated healthcare delivery system.

Achievement levels
Fully successful: 65% of employees indicate they know the mission.
Exceptional: 80% of employees indicate they know the mission.

Network X Director Date

Jule D. Moravec, Ph.D. Date
Chief Network Officer

Kenneth W. Kizer, M.D., M.P.H. Date
Under Secretary for Health

1997 NATIONAL AMBULATORY CARE CUSTOMER SATISFACTION SURVEY

Customer Service Standards with Component Questions

Timeliness/Access

Were you able to get this clinic appointment as soon as you wanted?

Were you able to schedule this appointment the first time you tried?

On the day of the appointment, how long did you wait in line to check in?

How long after the time when your appointment was scheduled to begin did you wait to see the provider?

Do you think your problem should have been handled sooner?

What happened when you called for an appointment?

Did you have to wait too long in the *waiting room*?

Did you spend as much time with your provider as you wanted?

Education

When you asked questions, did you get answers you could understand?

Did the provider explain why you needed tests in a way that you could understand?

After tests were done, did the provider explain the results in a way that you could understand?

Did someone explain the purpose of any prescribed medicines in a way you could understand?

Did someone tell you about side effects of your medicines in a way you could understand?

Did the provider explain what to do if problems or symptoms continued, got worse, or came back?

Did you get as much information about your health and/or treatment as you wanted from the provider?

Preferences

When you saw the provider, did he or she give you a chance to explain the reason for your visit?

Did the provider listen to what you had to say?

Were you involved in decisions about your care as much as you wanted?

Was the provider willing to talk to your family or friends about your health or treatment?

Did provider ask how your family or living situation might affect your health?

Did your provider encourage you when you tried to improve your health (diet, exercise, smoking)?

Did you feel that you were treated like a second class citizen?

Emotional Support

Did the provider look you in the eye when you talked, rather than at the chart or elsewhere?

Did you have concerns that you wanted to discuss but did not?

If you and the provider did not talk about your concerns, was it because...

Emotional Support *(continued)*

Did you have confidence and trust in the provider you saw?

Did you have trouble understanding the provider because of a language problem?

Coordination of Care

Were the providers who cared for you always familiar with your most recent medical history?

Were there times when one of your providers did not know about tests you had or their results?

Were there times when one of your providers did not know about changes in your treatment that another provider recommended?

Were there times when you were confused because different providers told you different things?

Did you always know what the next step in your care would be?

Did you know who to ask when you had questions about your health care?

Did someone tell you *how* you would find out the results of your tests?

Did someone tell you *when* you would find out the results of your tests?

If you needed another visit with *this provider*, did the staff do everything they could to make the necessary arrangements?

If you were referred to *another provider*, did the staff do everything they could to make the necessary arrangements?

Did you know who to call if you needed help or had more questions after you left your appointment?

Has your provider or anyone on your health care team discussed home care needs with you?

Continuity of Care

Is there one provider or team in charge of your VA care?

Courtesy

Was the person who made your appointment courteous?

Were you treated with courtesy and respect by the provider?

Overall Evaluation/Satisfaction

Was the main reason you came for this visit addressed to your satisfaction?

How organized was the clinic you visited?

CHRONIC DISEASE INDEX

Definition: Consists of 14 medical interventions that asses how well VHA follows nationally recognized guidelines for five high volume diagnoses: ischemic heart disease, hypertension, chronic obstructive pulmonary disease (COPD), diabetes mellitus, and obesity. Within each of the five diagnoses, there are two to five medical interventions that are measured.

Chronic Disease Index	*Measures*
Ischemic Heart Disease	**Acute myocardial infarction inpatients**
Aspirin Use	Ischemic heart disease (IHD) patients for whom aspirin is appropriate who were taking aspirin at their most recent outpatient visit.
Beta Blocker Use	IHD patients for whom beta blockers are appropriate who were taking beta blockers at their most recent outpatient visit
Cholesterol Management Plan	IHD patients who were taking statins, fibric acid derivatives, or other drugs to lower cholesterol at their most recent outpatient visit; or who had been counseled about physical activity or nutrition to manage cholesterol; or who had been referred to a cardiac rehabilitation program.
Hypertension	**Outpatients with active diagnosis of hypertension**
Weight Counseling	Documentation of counseling about weight control during past two years in patients.
Exercise Counseling	Documentation of counseling about exercise during past two years in appropriate patients with hypertension.
COPD	**Outpatients with active diagnosis of chronic pulmonary disease (COPD)**
Inhaler Observation Outpatients	Persons with chronic obstructive pulmonary disease on inhaled drugs, first receiving an inhaler in the past three years, with documentation that they were instructed and observed using inhaler properly.
Inhaler Observation Inpatients	Persons with chronic obstructive pulmonary disease using an inhaler, admitted to the hospital in the past three years with diagnosis of COPD, whose use of inhaler was subsequently observed and corrected if necessary.

Diabetes mellitus		**Outpatients with active diagnosis of diabetes mellitus**
	Inspection of Feet	Diabetics other than bilateral amputees with past year documentation of visual inspection of feet.
	Examination of Pedal Pulses	Diabetics other than bilateral amputees with past year documentation of examination of pedal pulses.
	Sensory Examination of Feet	Diabetics other than bilateral amputees with past year documentation of foot sensory examination.
	Retinal Eye Exam	Diabetics with documentation of past year funduscopic examination of the retina.
	Hemoglobin A1c	Diabetics with documentation of past year hemoglobin A1c determination.
Obesity		**Outpatients with body mass index greater than 27 at most recent visit when weight was measured.**
	Nutrition Counseling	Overweight persons with documentation of nutrition counseling during past two years.
	Exercise Counseling	Overweight persons with documentation of counseling about exercise during past two years.

PREVENTION INDEX

Definition: Consists of 9 medical interventions that measure how well VHA follows nationally recognized primary prevention and early detection recommendations for eight diseases with major social consequences. The eight diseases are influenza and pneumococcal diseases; tobacco consumption; alcohol abuse; and, cancer of the breast, cervix, colon and prostate. These interventions are largely drawn from the 1996 Guide to Clinical Preventive Services published by the U.S. Preventive Services Task Force. Within each of the eight diseases, there are one to two medical interventions measured.

Prevention Index	*Measures*
Immunizations	
Pneumococcal Vaccination	Persons age 65 or older or at high risk of pneumococcal disease with documentation of ever receiving pneumoccocal vaccine.
Influenza Immunization	Persons age 65 or older or at high risk of complications of influenza with documentation of receiving influenza vaccine in the past year.
Screening	
Screening for Breast Cancer	Females age 50 to 69 with documentation of mammography in the past two years.
Screening for Cervical Cancer	Females 65 and younger who have not had hysterectomy with documentation of a Pap smear in the past three years.
Screening for Colorectal Cancer	Persons age 50 or older with documentation of fecal occult blood screening in the past year or sigmoidoscopy in the past ten years.
Counseling Regarding Prostate Cancer Screening	Males age 50 and older with documentation in the chart of past year discussion of risks and benefits of prostate specific antigen testing.
Tobacco Consumption	
Tobacco use screening	Persons whose charts document screening for tobacco use in the past year.
Counseling for Smoking Cessation	Current smokers whose charts document advice to stop smoking in the past year.
Alcohol Consumption	
Screening for Alcohol Use	Persons whose charts document screening for alcohol using a standardized instrument.

END OF LIFE CARE PLANNING

Patients with terminal diagnoses or conditions in final stages of illness, receiving ongoing care through VA, will have documentation of an individualized plan for comprehensive, coordinated, end of life care services that minimizes physical and psychological suffering and optimizes the patient's quality of life.

Charts will be screened for clinician documentation that suggests the patient is imminently terminal. If documentation is found, the chart will be reviewed for the following evidence:

- *Admission to a Medicare-certified hospice program, VA hospice program, or VA Home Based Primary Care; or*
- *An individualized plan that includes:*
  - *Discussion of care alternatives and treatment settings with the patient and/or family*
  - *Discussion of Resuscitation Status*
  - *Plan for palliative symptom management (e.g., pain, dyspnea)*
  - *Offer of psychosocial and/or spiritual counseling and support*
  - *Hospital discharge planning, including instructions and referral to resources (e.g., caregiver support and respite, etc.)*

END OF LIFE CARE PLANNING

DENOMINATOR	The sum of the patients with cancer, chronic obstructive pulmonary disease (COPD), or congestive heart failure (CHF) included in the review
Specific or metastatic cancer	Patients who were discharged from the hospital with a diagnosis of cancer, with primary site in the esophagus, pancreas, or liver; or who were discharged with a diagnosis of metastatic cancer of the colon, trachea, bronchus, or lung, breast, or prostate, or metastatic melanoma, and who had not received adjuvant or curative chemotherapy or radiotherapy.
COPD or CHF	Patients who were discharged from the hospital with principal diagnosis of CHF or COPD, who had at least three admissions or one intensive care unit admission during a 6 month period.
NUMERATOR	Total number of patients in the denominator whose records show they were enrolled in either hospice care or equivalent (VA hospice program, community hospice program, or VA Home-Based Primary Care) or received individualized comprehensive end of life services as defined below.
VA Hospice	Number of patients in the denominator whose records documented admission to a VA hospice program.
Other Hospice	Number of patients in the denominator whose records document admission to a community hospice program.

Home-based primary care	Number of patients in the denominator whose records document admission to a VA Home-Based Primary Care.
Individualized comprehensive services	Number of patients in the denominator whose records document each appropriate element of individualized care enumerated below.
PATIENTS ELIGIBLE FOR INDIVIDUALIZED CARE	
Resuscitation status discussed	Total number of patients in the denominator who were not admitted to a hospice or equivalent program, whose records document discussion of resuscitation status with the patient, patient's family, or legal representative.
Nutrition/hydration assessed	Total number of patients in the denominator who were not admitted to a hospice or equivalent program, whose records document assessment of nutritional and/or hydration needs.
Psychosocial support	Total number of patients in the denominator who were not admitted to a hospice or equivalent program, whose records document that the patient and/or family were provided emotional or social support or guidance by a psychiatrist, psychologist, nurse, family therapy counselor, Social Services staff, chaplain, or attending physician.
Care giver support and instructions: patients discharged home	Total number of patients in the denominator who were not admitted to a hospice or equivalent program, who were discharged home at least once, whose records document both that the patient, family, or other care giver was provided instructions for post-hospital care and that the family or other care giver was made aware of care giver support and respite services.
Pain treatment plan: patients with pain	Total number of patients in the denominator who were not admitted to a hospice or equivalent program, whose records document that they experienced cancer pain, whose records also document a plan of treatment for the pain.
Dyspnea treatment plan: patients with dyspnea	Total number of patients in the denominator who were not admitted to a hospice or equivalent program, whose records document that they experienced dyspnea, whose records also document a plan of treatment for the dyspnea.
Depression treatment plan: patients with depression	Total number of patients in the denominator who were not admitted to a hospice or equivalent program, whose records document that they experienced depressed mood or affect, whose records also document a plan of treatment for the depressed mood or affect.

Mr. HINCHEY. Well, Mr. Chairman, you have asked the followup questions that I was intending to ask because I think it is important to clarify this situation. Normally when people think, citizens think, about the people who work for the Federal Government, they generally think of them as being covered by Civil Service. But that is not the case in this particular situation, I gather, Dr. Wilson.

People in supervisory positions—well, Mr. Farsetta, you are not a Civil Service employee.

Mr. FARSETTA. Oh, yes, I am.

Mr. HINCHEY. You are? You are covered under Civil Service?

Mr. FARSETTA. Well, we're part of the Senior Executive Service, which is part of Civil Service, yes.

Mr. HINCHEY. And under that circumstance, there is a ruling which provides for the Veterans Administration to provide bonuses to people for what is evaluated to be a higher degree of service?

Mr. FARSETTA. Yes.

Ms. WILSON. Technically, it's a performance award. My understanding is that the Federal Government does not give bonuses, but it is a performance award. But to me it's the same thing.

Mr. HINCHEY. Pretty much the same thing, isn't it?

Ms. WILSON. Yes. I'm just trying to be precise. I apologize to the group.

Mr. HINCHEY. Well, I think the concerns of the Members of Congress are apparent at this particular——

Mr. SHAYS. Excuse me. Would the gentleman suspend? Excuse me. We need order here. Thank you.

You have the floor.

Mr. HINCHEY. I would just say this for myself. Particularly in view of my experience over the course of the last couple of years with the VA, conversations I have had, questions that I have asked and not received answers to, my experience over the last couple of years raises certain questions. And at question here is the issue of motivation.

And what is on the minds of the Members of Congress is: Have we gotten to a point where we are rewarding people in sensitive positions within the Federal Government to cut funding, cut the amount of money that is being spent in such a way that jeopardizes the people that are supposed to be served? [Applause.]

And I raise this this way because this is an important public policy consideration, one that needs to be examined by this committee, by the Congress, and by the administration. I think that is critically important.

Now, I understand what is driving this. What is driving this is the alleged need to balance the budget and to cut funding and all of that business. But it seems to me in my observations recently that we have gone over the edge and that too much of our decisions are being driven purely by fiscal matters and not enough of them are being driven by human considerations. [Applause.]

I would hope—I'm sure that the VA administrator, the acting administrator, Dr. Kizer, and others are aware of these hearings and they will go over this testimony. And I think it's very important for us to look at this question because this is a fundamental issue of public policy. And I think it is one that has to be reviewed because it's my judgment that we have gone too far. [Applause.]

Mr. SHAYS. Thank you.

Mr. Gilman has a followup question. Then we're going to go to our next panel.

Mr. GILMAN. Dr. Wilson, in looking over the incentive measures under the performance agreement, I find that—I'm looking at the old one. If this differs from the new one, please let me know. We're looking at the performance measures.

The denominator for calculating the percentage of patients enrolled in primary care will be ambulatory care customer satisfaction. And to be fully successful, 65 percent of the patients enrolled in primary care, exceptional performance requires that 90 percent of VISN number of patients in the aggregate be enrolled in primary care. Is that still part of the performance?

Ms. WILSON. Yes, it is. And the percentage is calculated on the basis of veterans who are surveyed with the customer, patient, satisfaction survey and answer "Yes" to the question "Is there one person or a team in charge of your care?" We call that primary care enrollment.

Mr. GILMAN. With regard to ambulatory surgery, your achievement level states, "To be considered fully successful, at least 25 percent of the surgical cases performed in VISN or 50 percent of the surgical and invasive diagnostic procedures combined will be performed on an ambulatory basis. And to be considered exceptional, 40 percent of surgical cases performed in VISN or 65 percent of the surgical and invasive diagnostic procedures combined will be performed on an ambulatory basis." Is that still part of your performance criteria?

Ms. WILSON. The ambulatory surgery measure is still in effect.

Mr. GILMAN. And then with the——

Ms. WILSON. The targets, the goals have changed, however; 65 percent is fully successful, and 75 percent is exceptional.

Mr. GILMAN. With regard to bed days of care, "Achievement levels to be considered fully successful, bed days of care per patient will decrease for all VISN number of patients in the aggregate by 20 percent and to be considered exceptional, bed days of patients will decrease in the aggregate by 30 percent." Is that still part of your performance criteria?

Ms. WILSON. The targets have changed. In 1997, we were able to obtain Medicare data for the country. And the target for each network was to reach where Medicare, where we would project Medicare, patients to be in 1997. This network's target was 7 percent, was to decrease bed days of care 7 percent, which would put it in line with this region's Medicare standard of care.

Mr. GILMAN. So essentially, then, your overall program provides incentives if you decrease primary care, if you decrease surgery and make it ambulatory surgery, and if you decrease bed days. Is that correct?

Ms. WILSON. No. Those are three measures out of the total number of measures.

Mr. GILMAN. But they are included. Is that——

Ms. WILSON. These are included in the 1997 agreement with the targets as I stipulated.

Mr. GILMAN. They seem to be pretty essential elements that have reduced the quality of care in our region.

Ms. KELLY OF NEW YORK. Will the gentleman yield?

Mr. GILMAN. Yes.

Ms. KELLY OF NEW YORK. Thank you.

I have one more question for Dr. Wilson. Dr. Wilson, if it turns out that oversight is lacking in the VA by what the GAO study says that we think will probably be a part of the Senate request, if it turns out that the oversight is lacking, will you allow further GAO study to happen? Will the VA allow for further study? And will you slow down the VERA program until we are sure that VERA will not be in a position to offer poorer quality medical care for the patients in our area?

Ms. WILSON. I don't have the authority to answer that question. My understanding with GAO is that they're an independent review organization, and I wouldn't have the authority to slow them down.

Ms. KELLY OF NEW YORK. I am talking about VERA. Do you think there's a chance that the VERA program would slow down until we get this GAO study in terms of oversight?

Ms. WILSON. I have no authority to answer that.

Ms. KELLY OF NEW YORK. Thank you.

Mr. SHAYS. Thank you.

Our panel will be staying through the conclusion of this hearing. And I, frankly, as someone who is in charge of this hearing feel a little guilty. And I want to say this to you, that we have dedicated public servants, whom you may have strong disagreements with—I'm speaking to the audience now—but they are dedicated public servants who have served this country long and hard. Mr. Farsetta, how long have you served?

Audience PARTICIPANT. So have we.

Mr. FARSETTA. Twenty-nine years.

Mr. SHAYS. Mr. Farsetta, you've served 29 years as a civil servant or a political appointee?

Mr. FARSETTA. Civil servant.

Mr. SHAYS. You are a civil servant. I want to thank you, Mr. Farsetta, for your service to our country during those 29 years, and the rest of this panel and Dr. Wilson as well and to Mr. Sabo and Mrs. Musumeci. I want to thank our panel for being here. I want to thank them for responding to our questions. And we will now go to our second panel.

Mr. FARSETTA. Thank you.

Mr. SHAYS. The second panel is: Mr. Lawrence Dos Santos, deputy director, New York State Division of Veterans Affairs; Mr. Thomas C. Agnew, director, Orange County Veterans Service Agency; Mr. Jerry Donnellan, director, Rockland County Veterans Service Agency; Mr. Al Etkin, director, Sullivan County Veterans Service Agency; and Mr. Jim Whoie, deputy director, Dutchess County Veterans Service Organization.

I'd like to make an announcement. Evidently I'm being asked to make an announcement that in 10 minutes the bus to Castle Point, the Leprechaun buses, will be leaving in 10 minutes back to Castle Point.

Audience PARTICIPANT. How come we can't be heard?

Mr. SHAYS. Ma'am, if you want to stay longer, you will be heard.

Audience PARTICIPANT. How are we going to get home?

Mr. SHAYS. Will the witnesses please stand? Would you raise your right hands, please? Do you solemnly swear or affirm that the testimony you will give before the subcommittee will be the truth, the whole truth, and nothing but the truth?

Mr. DOS SANTOS. I do.

Mr. AGNEW. I do.

Mr. DONNELLAN. I do.

Mr. ETKIN. I do.

Mr. WHOIE. I do.

Mr. SHAYS. We're just going to go down the list after we have order. We will suspend until people have left who want to leave.

[Pause.]

Mr. SHAYS. Mr. Santos, we're prepared to hear your testimony.

Mr. DOS SANTOS. Thank you.

Mr. SHAYS. Mr. Santos, we are going to hear your testimony. We are not going to followup with any questions to any of the Service representatives. And then we'll be going to the floor and listening to testimony and again not following up with questions so we can cover more people.

Mr. DOS SANTOS. I think that's a great idea.

Mr. SHAYS. OK. Thank you, Mr. Santos. There are people moving in and out. So you're going to have to speak even a little louder.

Mr. DOS SANTOS. I will. Good afternoon.

Mr. SHAYS. Good afternoon.

STATEMENTS OF LAWRENCE DOS SANTOS, DEPUTY DIRECTOR, NEW YORK STATE DIVISION OF VETERANS' AFFAIRS, ACCOMPANIED BY THOMAS C. AGNEW, DIRECTOR, ORANGE COUNTY VETERANS SERVICE AGENCY; JERRY DONNELLAN, DIRECTOR, ROCKLAND COUNTY VETERANS SERVICE AGENCY; AL ETKIN, DIRECTOR, SULLIVAN COUNTY VETERANS SERVICE AGENCY; AND JIM WHOIE, DEPUTY DIRECTOR, DUTCHESS COUNTY VETERANS SERVICE ORGANIZATION

Mr. DOS SANTOS. My name is Lawrence Dos Santos. And I am the deputy director, southern region of the New York State Division of Veterans' Affairs. I want to point out it's not my testimony. I have had the distinct honor and privilege of serving my country in the U.S. Marine Corps in Vietnam as an infantry fire team leader with Company C, First Battalion, Fourth Marines. Ooh-rah.

On behalf of Director John L. Behan, who was retired at the rank of Sergeant from the United States Marine Corps after being severely wounded in Vietnam while serving with Bravo Company, First Battalion, First Marines, First Marine Division, I want to thank you, Chairman Shays, Congresswoman Sue Kelly, Congressman Benjamin Gilman, and Congressman Hinchey, for your interest and commitment to the veterans of New York State and for your timely response to the concerns that will be aired here today by veterans and families who are troubled about the diminishing quality of care offered at the United States Department of Veterans Affairs medical facilities in the Hudson Valley.

For the past year, the New York State Division of Veterans' Affairs has repeatedly warned that the VA's Veterans Equitable Resource Allocation [VERA] program was nothing short of bad news for our State's 1.5 million veterans, who would be shortchanged by

the shift of nearly $180 million from the Empire State to other States around the Nation. This program, while intended to fairly distribute health care funds throughout America, is anything but equitable to the veterans in New York and other Northeastern States.

This program was hastily implemented without adequate study or research on how the loss of tens of millions of dollars at individual medical facilities would impact the care and service provided our aging and sick veterans dependent on VA hospitals. That is why we are here today. This program has not and will not work in New York State as it has been implemented.

In presenting and defending VERA, then Secretary Jesse Brown promised that no veteran receiving health care presently would be denied care under the new allocation program and that budget cuts at individual facilities would be absorbed through greater efficiency.

No one outside of the VA bought that promise, especially veteran leaders in our State. Efficiency normally is achieved through fewer employees doing more, not by abolishment of crucial programs, such as mental health care, dialysis treatment, nursing home care, and homeless programs, which is what has happened in New York State.

The implementation of VERA has now pitted veteran against veteran and State against State for medical funds which have been inadequately appropriated Nationally and inequitably appropriated for individual States. This is a tragedy for our veterans and for the VA, whose proud legacy of competent professional and compassionate health care is being tarnished with reports and accusations of neglect of patients.

Greater efficiency is a goal we should all strive for in Government, but we must be aware that there is a difference in trimming the fat from a budget and bare-boning to the point of crippling programs.

The tales of patient neglect and rising deaths at VA hospitals at Castle Point and Montrose, which will be presented here today, are not unique to the Hudson Valley. We at the Division of Veterans' Affairs have heard similar allegations from veterans and families from other areas of the State, including western and upstate New York and the metropolitan area.

Veterans and their loved ones are dismayed and fearful. VA hospitals were once a beacon of hope. Now, however, veterans are being turned away for care they once took for granted or are being told that they have to go elsewhere, often distant points, for treatment or, as we are hearing, they are getting inadequate care.

We are concerned with the changing policies and practices at the VA, but I want to stress that our anxiety is with the administration and not the medical facility employees, who are as much a victim of VERA as our veterans. [Applause.]

Historically, the VA has employed dedicated and compassionate health care providers, whose professionalism and commitment are top of the line. VERA, however, has imposed tremendous hardship on these devoted care-givers, who now have become like Marines, made to do more with less. It's something I'm quite familiar with. It is not fair to them or their patients.

VERA is now a catalyst for the VA and our Government to dismantle a health care program that has been a lifeline for millions of American patriots, particularly our older, infirm, and poor vets.

We cannot allow that to happen. Professional and competent treatment and care at a VA hospital is a benefit that most veterans expect to receive from a grateful Nation for their service and sacrifice in our armed forces.

Many of these men and women were promised this care by recruiters—remember them—eager to get them in uniform to defend our country and its precious principles. For many veterans, health care is the only benefit claimed from military service, and the least they should expect is that that care is available and safe. Care at a VA hospital should not and must not be a death sentence, as some now fear. And certainly its availability should not be determined by what State you call home.

The New York State Division of Veterans' Affairs, on behalf of our veterans, urges Congress and the administration of Washington, DC, to take immediate action to halt staffing layoffs and reduction of staffs at VA medical centers and to place a moratorium on the implementation of VERA until such time as the veterans' community can be assured that any spending shifts or cuts will not adversely impact their rights and benefits.

"I told you so" is a phrase no one likes to hear. Critics of VERA take no pleasure in uttering that statement. The failure of VERA has not been borne by nor impacted the bureaucrats who thought up this scheme. But, rather, it has tragically been endured by veterans and their loved ones, whose pain and suffering made this hearing today necessary.

On behalf of Director Behan and the New York State Division of Veterans' Affairs, I urge this committee to take the lead in restoring the credibility of our Government and the VA by creating a new funding mechanism to provide the money necessary to guarantee all of America's veterans are treated like the first-class citizens they are.

I'd like to add one more statement before I close. I'd like to point out that these three Members of Congress here from this State are the only ones I know of that have taken on VERA and have been as vocal and spoken out as much. And I'd like to personally thank you. John Behan asked me to make sure I made that statement to all three of you, and we thank you so very much for caring about us.

Thank you for the opportunity to be here and to speak to you today. And God bless everyone here.

[The prepared statement of Mr. Dos Santos follows:]

STATE OF NEW YORK
EXECUTIVE DEPARTMENT
DIVISION OF VETERANS' AFFAIRS
5 Empire State Plaza
Suite 2836
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John L. Behan
Director

Committee on Government Reform and Oversight Subcommittee on Human Resources

Rep. Christopher Shays, Chairman

August 4, 1997 - Wallkill Community Center, Middletown, New York

Statement of New York State Division of Veterans' Affairs

Good afternoon. My name is Lawrence Dos Santos and I am the Deputy Director, Southern Region of the New York State Division of Veterans' Affairs. On behalf of Director John L. Behan, I want to thank you Chairman Shays, Congresswoman Sue Kelly and Congressman Benjamin Gilman for your interest and commitment to the veterans of New York State, and for your timely response to the concerns that will be aired here today by veterans and family members who are troubled about the diminishing quality of care offered at the United States Department of Veterans Affairs (VA) medical facilities in the Hudson Valley.

For the past year, the New York State Division of Veterans' Affairs has repeatedly warned that the VA's Veterans Equitable Resource Allocation (VERA) program was nothing short of bad news for our state's 1.5 million veterans, who would be shortchanged by the shift of nearly $180 million from the Empire State to other states around the nation.

This program, while intended to fairly distribute health care funds throughout America, is anything but equitable to the veterans community in New York and other northeast states. This program was hastily implemented without adequate study or research on how the loss of tens of millions of dollars at individual medical facilities would impact the care and service provided our aging and sick veterans dependent on VA hospitals.

That is why we are here today. This program has not, and will not, work in New York State as it has been implemented.

In presenting and defending VERA, then-Secretary Jesse Brown promised that no veteran receiving health care presently would be denied care under the new allocation program, and that budget cuts at individual facilities would be absorbed through greater efficiency.

No one -- outside of the VA – bought that promise, especially veterans leaders in our state. Efficiency normally is achieved through fewer employees doing more, not by abolishment of crucial programs such as mental health care, dialysis treatment, nursing home care and homeless programs, which is what has happened in New York.

The implementation of VERA has now pitted veteran against veteran and state against state for medical funds which have been inadequately appropriated nationally, and inequitably appropriated for individual states.

This is a tragedy for our veterans, and for the VA whose proud legacy of competent professional and compassionate health care is being tarnished with reports and accusations of neglect of patients.

Greater efficiency is a goal we should all strive for in government. But we must be aware that there is a difference in trimming the fat from a budget, and bare-boning to the point of crippling programs.

The tales of patient neglect and rising deaths at VA hospitals at Castle Point and Montrose, which will be presented today, are not unique to the Hudson Valley. We at the Division of Veterans' Affairs have heard similar allegations from veterans and families from other areas of the state, including western and upstate New York, and the metropolitan area.

Veterans – and their loved ones – are dismayed and fearful. VA hospitals were once a beacon of hope. Now, however, veterans are being turned away for care they once took for granted, or are being told that they have to go elsewhere, often distant points, for treatment, or, as we are hearing, they are getting inadequate care.

We are concerned with the changing policies and practices at the VA, but I want to stress that our anxiety is with the administration and not the medical facility employees, who are as much a victim of VERA as our veterans.

Historically the VA has employed dedicated and compassionate health care providers, whose professionalism and commitment are top of the line. VERA, however, has imposed tremendous hardship on these devoted care-givers, who now have become more like Marines -- made to do more with less. It is not fair to them or their patients.

VERA is now a catalyst for the VA and our government to dismantle a health care program that has been a lifeline for millions of American patriots, particularly our older, infirm and poor veterans.

We cannot allow that to happen. Professional and competent treatment and care at a VA hospital is a benefit that most veterans expect to receive from a grateful nation for their service and sacrifice in our armed forces. Many of these men and women were promised this care by recruiters eager to get them in uniform to defend our country and its precious principles. For many veterans, health care is the only benefit claimed from military service, and the least they should expect is that it is available and safe. Care at a VA hospital should not and must not be a death sentence – as some now fear – and, certainly, its availability should not be determined by what state you call home. (Last page missing?)

Mr. SHAYS. Thank you. [Applause.]

Thank you, Mr. Dos Santos.

Mr. Agnew.

Mr. AGNEW. Thank you.

Mr. Shays, Mr. Hinchey, Mr. Gilman, Mrs. Kelly, I appreciate the opportunity to share my views as director of the Orange County Veterans Service Agency and also as a two-tour combat veteran of Vietnam and also as a veteran of seven major Service-connected surgeries. So I know my way around hospitals a little bit from the other side. The current status of local VA health services after the VERA funding cuts is the subject.

Most of the Orange County resident veterans who avail themselves of VA health care use the services provided at VA Medical Center at Castle Point. For certain specialties and illnesses, VA Medical Centers at Albany, Montrose, Bronx, and Manhattan are also used. The VA has been an integral part of health care delivery system in the Hudson Valley for many years.

The implementation of the Veterans Equitable Resource Allocation may, in fact, achieve certain of its goals when viewed from other parts of the country. Few veterans advocates, myself included, would oppose allocating funds to areas where veterans are truly under-served or of allowing funds to follow veterans who are relocating in large numbers.

The shifting of funds under VERA, however, appears to follow a pattern of reducing high-cost area operations in favor of low-cost operations. Few would deny that it is more expensive to deliver medical care in New York City as opposed to Jackson, MS or Houston, TX.

Mr. SHAYS. Excuse me.

Mr. AGNEW. While this may appear to make fiscal sense——

Mr. SHAYS. Mr. Agnew, I've just been told to remind whoever is going to Castle Point on the bus that the bus is ready to leave right now if there is anyone still in the room. I'm sorry to interrupt you.

Mr. AGNEW. That's OK. The fact of the matter is that the New York veterans are still here and the funds, frankly, are not.

In our local case, the VISN which covers Castle Point and the New York centers was mandated in September 1995 to reduce the budget by $148 million over 3 years. It is now August 1997, and $130 million have already been cut. This massive a reduction so quickly denies the local communities an opportunity to assess the impact of reductions as they occur, as would be the case if these cuts were taken over 3 years.

The Castle Point facility has lost more than 200 employees since 1995. Whether they were bought out, retired, laid off, or fired, the facts are that they are gone. They used to do something, and that is now done by someone else or it's not done at all. Castle Point is staffed by some very excellent and caring people. It is, however, a facility under strain, as are all of the area facilities.

Now, you are no doubt going to hear during this session stories of patient abuse and poor service. If these stories are true and complete, they must be dealt with accordingly. Please keep in mind that this facility provides some excellent service to thousands of area veterans at a time when their health care options are bringing

more and more vets to the VA for care. It is, therefore, essential that Castle Point and all of the VA medical facilities in the area and, indeed, the Northeast be saved and strengthened.

Thank you.

[The prepared statement of Mr. Agnew follows:]

Joseph G. Rampe
County Executive

VETERANS SERVICE AGENCY

Thomas C. Agnew
Director
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TEL (914) 291-2470 · FAX (914) 291-2558

July 23, 1997

Subcommittee on Human Resources
Christopher Shays, Connecticut Chairman
Room B-372 Rayburn Building
Washington, D.C. 20516

Dear Mr. Shays:

I appreciate the opportunity to share my views as Director of the Orange County Veterans Service Agency, on the current status of local VA health services after the VERA funding cuts. Most of the Orange County resident veterans who avail themselves of VA health care, use the services provided at the VA Medical Center at Castle Point. For certain specialties and illnesses, the VA Medical Centers at Albany, Montrose, Bronx, and Manhattan are also used. The VA has been an integral part of the health care delivery system in the Hudson Valley for many years.

The implementation of the Veterans Equitable Resource Allocation may, in fact, achieve certain of its goals when viewed from other parts of the country. Few veterans advocates, myself included, would oppose allocating funds to areas where veterans are truly underserved or of allowing funds to follow veterans who are relocating in large numbers.

The shifting of funds under VERA, however, appears to follow a pattern of reducing high cost area operations in favor of low cost operations. Few would deny that it is more expensive to deliver medical care in New York City as opposed to Jackson, Mississippi or Houston, Texas. While this may appear to make fiscal sense, the fact is that the New York veterans are still here and the funds are not.

In our local case, the VISN which covers Castle Point and the New York Centers was mandated in September of 1995 to reduce the budget by 148 million dollars over three years. It is now August of 1997 and 130 million dollars have already been cut. This massive a reduction so quickly denies the local communities an opportunity to assess the impact of reductions as they occur as would be the case if the cuts were, in fact, taken over three years.

The Castle Point facility has lost more than two hundred employees since 1995. Whether they were bought out, retired, laid off, or fired, the facts are that they are gone and that they used to do something that is now done by someone else or not done at all. Castle Point has, I believe, been able to maintain an adequate nurse to patient ratio and it is staffed by some very excellent and caring people. It is, however, a facility under strain as are all of the area facilities.

You will no doubt hear during this session stories of patient abuse or poor service. If these are true and complete, they should be dealt with accordingly. Please keep in mind that this facility provides some excellent services to thousands of area veterans at a time when health care options are bringing more and more veterans to the VA for care.

It is, therefore, essential that Castle Point and all of the VA medical facilities in the area and indeed in the Northeast be saved and strengthened.

Sincerely yours,

THOMAS C. AGNEW,
Director

TCA:can

Mr. SHAYS. Thank you, [applause.] Mr. Agnew.

Mr. Donnellan.

Mr. DONNELLAN. First I would like to thank the Members of Congress as well as the members of the VA staff and Mr. Farsetta and his folks for coming over to listen.

Rather than read verbatim from my text—you have that in copy, and it does repeat many things that have already been said—I would like to just ask that all of these investigations be done as rapidly as possible and as unbiased as possible because we are hearing the ills. And, as Mr. Agnew said, there are good ones.

We in our district, Mr. Gilman's district, have developed a VA outpatient clinic that without the help of the VA wouldn't exist. That has brought care to 10 times, literally 10 times, the number of veterans that were served the previous year.

Also, the speed I think is important as to eliminate the collateral damage that's being done in that staff members, nurses, kitchen people, all members of the staff of the VA hospitals, are taking flack for these hearings. These are in general good people who have worked very hard. And there are many good veterans being served quite well. So let's do our cutting with the scalpel, not with the axe, and let's do it as quickly as possible.

Thank you. [Applause.]

Mr. SHAYS. Thank you, Mr. Donnellan.

Mr. Etkin.

Mr. ETKIN. Mr. Chairman, Members of Congress, fellow veterans, thank you for allowing me the opportunity to appear today and offer testimony regarding the VA health care situation as it affects our veterans in the Castle Point and Montrose VA catchment areas.

In addition to my appearance primarily as the director of the Sullivan County Veterans Service Agency, as the lead advocate for my county's military veterans and their families, I also appear as the hospital chairman for the Veterans of Foreign Wars Department of New York, as the Sullivan County commander of the American Legion, and as the commander of the Jewish War Veterans post in Sullivan County. So please regard my comments as spokesperson for these veterans' organizations.

Better than 51 percent of Sullivan County's population is representative of the veteran community, making us the largest category of any in the county, including seniors. Since the situation regarding veteran care at both Castle Point and Montrose VA began back in May of this year, all of the media reports were indicative of cases involving both Dutchess and Orange Counties. There was not one example of poor patient care or deaths concerning Sullivan County resident veterans.

Now, we transport veterans on a daily basis to Castle Point VA and have done so for the past 46 years. During the past 3½ years that I've held my office and upon my frequent visits to our county's inpatients, 99 percent of our veterans have told me that they could not have received better care; now, this after asking them specifically if they were, in fact, receiving good care and attention and if there was anything that I could do to personally assist them. So that speaks well for the medical staff attending them.

When, in fact, there were or are situations needing attention for veterans and I'm informed by them, I can easily access the Chief of Medical Administration or the Medical Director's office. And that situation is readily corrected to the veteran's satisfaction. So in this regard, I cannot do less than commend the staff at both facilities for which we have found to be jobs well done. [Applause.]

I want to call to your attention at this time that our veteran standing committee as well as the Sullivan County legislature passed resolutions to support the maintenance of the medical services for our honorably discharged veterans at all of our Nation's 172 VA medical centers, and especially at the Castle Point VA, but to condemn the actions of the Department of Veterans Affairs in the elimination of the inpatient surgery at Castle Point VA and possible further staff reductions. In addition, it was resolved to support continued VA funding to the Northeast region of the United States and not to the shifting of funds to other parts of the country.

We question how the elimination of some 200 staff positions at Castle Point will allow the quality of care to our veterans to be maintained with less staff to provide the same level of services.

At the same time, we question how our New York delegation members working as a block could vote to shift funds to other parts of the country if the effects of those shifts were not clear at the time of the vote. [Applause.]

We are concerned that once Castle Point VA was instructed to delete inpatient surgery, then the facility became a clinic, a nursing home, and loss status as a hospital medical center. We are further concerned that Acting Secretary for Veterans Affairs Hershel Gober promised to put in writing that Castle Point VA will remain open and not close.

The bottom line financially is that the VA budget has been slashed $5 billion over the next 5 years. Now, during the 104th Congress, the VA medical account was increased by $850 million over the past 2 years.

To ensure that adequate health care would be available for our Nation's veterans and because of the high population of veterans living in the Hudson Valley who depend upon and have earned the right to use this system, we were particularly concerned about the restructuring proposals by the Department of Veterans Affairs that shifted resources out of New York State to other parts of the country. And there was, in fact, no explanation of the formula as to how those resources were being shifted.

Adequate financial resources should be maintained to ensure proper medical care for our State's 1,900,000 veterans, of whom 520,000 are over the age of 65 with a projection that by 2000 this total will have increased to 600,000.

Now, as we are all aware but need to be reminded, following the conclusion of hostilities at the end of World War II, a promise was made by our Government that no veteran would be denied medical care at any VA medical center for the remainder of his or her life. [Applause.]

Our Nation's veterans have placed themselves at risk to preserve our country's freedoms and democratic principles. And any deletion of needed resources, supplies, and medical staff resulting in the

elimination of services and the inability to maintain the needed services to our veterans is considered unconscionable and mean-spirited.

Our Nation's veterans, both wartime and peacetime, have preserved our Nation. It is, therefore, the inherent obligation of our Nation to care for our veterans' medical needs to sustain their health and well-being.

Finally, the third party reimbursement moneys that formerly had to be returned to the general fund in Washington, DC, can now be well-utilized at our VA medical centers to increase needed staff and resources. These moneys can now be retained at the VAs. The volunteers that help assist our veterans are no longer in place to the high numbers they once were. It's time to do the right thing for our veterans and for our country.

Thank you for your attention. [Applause.]

[The prepared statement of Mr. Etkin follows:]

Sullivan County

Veterans' Service Agency

AL ETKIN
DIRECTOR

COUNTY GOVERNMENT CENTER
MONTICELLO, NEW YORK 12701
TEL. 914 794-3000
EXT. 3320

JOHN L. BRIDGES
ASST. DIRECTOR

STATEMENT OF AL ETKIN, DIRECTOR, VETERANS' SERVICE AGENCY, SULLIVAN COUNTY, NEW YORK, IN APPEARANCE BEFORE THE CONGRESSIONAL INQUIRY HELD AT MIDDLETOWN NEW YORK, AUGUST 4, 1997 AT 1:00 P.M.

* * * * * * * *

Thank you for allowing me the opportunity to appear today and offer testimony regarding the V.A. Health Care situation as it affects our veterans in the Castle Point and Montrose V.A. cachement area.

In addition to my appearance primarily as the Director of the Sullivan County Veterans' Service Agency, as the lead advocate for my county's military veterans and their families, I also appear as the hospital Chairman for the V.F.W. Department of New York, and as the Sullivan County Commander of the American Legion and the Commander of the Jewish War Veterans Post in Sullivan County. Please regard my comments as spokesperson for these veterans' organizations.

STATEMENTS OF RESOLUTIONS

Better than 51% of Sullivan County's population is representative of the veteran community, making us the largest category of any in the county, including seniors. Since the situation regarding veteran care at both Castle Point and Montrose V.A. began back in May of this year, all of the media reports were indicative of cases involved in both Dutchess and Orange counties. There was not one example of poor patient care or deaths concerning Sullivan County resident veterans. We transport veterans on a daily basis to Castle Point V.A., and have done so for the past 46 years. During the past 3 1/2 years that I have held my office, and upon my frequent visits to our county's in-patients, 99% of our veterans have told me that they could not have received better care. This after asking them specifically if they were, in fact, receiving good care and attention, and if there was anything that I could do to personally assist them. That speaks well for the medical staff attending them. When, in fact, there were, or are situations needing attention for veterans, and I am informed by them, I can easily access the Chief of Medical Administration, or the Medical Director's Office and that situation is readily corrected to the vet's satisfaction. So, in this regard, I cannot do less than commend the staff at both facilities for what we have found to be jobs "well done".

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We question how the elimination of some 200 staff positions at Castle Point will allow the quality of care to our veterans to be maintained with less staff to provide the same level of services?

At the same time, we question how our New York delegation members working as a bloc, could vote to shift funds to other parts of the country if the effects of those shifts were not clear at the time of the vote? We are concerned that once Castle Point V.A. was instructed to delete in-patient surgery, then the facility became a clinic and nursing home and lost status as a hospital/medical center.

We are further concerned that Acting Secretary for Veterans' Affairs, Hershel Gober, promised to put in writing that Castle Point V.A. will remain open and not close. The bottom line financially is that the V.A. budget has been slashed $5 billion over the next five years! During the 104th Congress, the V.A. Medical Account was increased by $850 million over the past two years, to ensure that adequate health care would be available for our nation's veterans, and because of the high population of veterans living in the Hudson Valley who depend upon and have earned the right to use this system, we were particularly concerned about the restructuring proposals by the Department of Veterans' Affairs that shifted resources out of New York State to other parts of the country and there was, in fact, no explanation of the formula as to how those resources were being shifted. Adequate financial resources should be maintained to ensure proper medical care for our state's one million, nine hundred thousand veterans, of whom 520,000 are over the age of 65, with a projection that by the 2000, this total will have increased to 600,000.

As we are all aware, but need to be reminded,.....following the conclusion of hostilities at the end of W.W.II, a promise was made by our government that no veteran would be denied medical care at any V.A. Medical Center for the remainder of his/her life, and our nation's veterans have placed themselves at risk to preserve our country's freedoms and democratic principles, and any deletion of needed resources, supplies and medical staff resulting in the

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Finally, the third party re-imbursement monies that formally had to be returned to the general fund in Washington, D.C. can now be well utilized at our V.A. Medical Centers to increase needed staff and resources. These monies can now be retained at the V.A.s. The volunteers that helped assist our veterans are no longer in place to the high numbers they once were. It's time to do the right thing, for our veterans and for our country.

Thank you for your attention.

Al Etkin, Director

Mr. SHAYS. Thank you, Mr. Etkin.

Mr. Whoie.

Mr. WHOIE. Good afternoon, Members of Congress.

Mr. SHAYS. Good afternoon.

Mr. WHOIE. I appreciate being able to speak with all of you this afternoon, and to include all of the veterans present. And that's all of us, I hope. I consider it a privilege to have been invited to participate in this very important endeavor.

I like to think that I am an advocate for veterans and their families. Since 1992, I have been allowed to practice the art of presenting issues and claims to the Department of Veterans Affairs. Over the years, in the opinion of many veterans that I come into contact with, a perception exists that medical care in general or in a general sense was not readily available. They are of the opinion that the VA, as I will call it henceforth, was on its last legs. Nickels, dimes, and quarters have slipped away, it appeared.

By and large, most of the veterans from World War II, Korea, and Vietnam are very concerned about medical care in general; that is to say, the availability of it, the quality of it, and the cost of it.

Today, at least in Dutchess County, NY, veterans have a serious concern about VA benefits in general, dissolving into nothingness. The concept that, "We want to take care of you," today in so many ways is simply hard for veterans to swallow.

Veterans and their families in large part believe that there is an unseen danger. They believe that the Veterans Affairs, at least when it comes to medical care, will cease to exist. Pride in what he or she did during a period of war seems lost in a myriad of legislative tactics.

Veterans in this community that I hope I represent have a question: If the government abandons that veteran today, may we abandon our duties as citizens tomorrow?

Thank you. [Applause.]

[The prepared statement of Mr. Whoie follows:]

I APPRECIATE THE OPPORTUNITY TO APPEAR BEFORE YOU TODAY, I CONSIDER IT A PRIVILEGE TO HAVE BEEN INVITED TO PARTICIPATE IN THIS VERY IMPORTANT ENDEAVOR. I LIKE TO THINK THAT I AM AN ADVOCATE FOR VETERANS AND THEIR FAMILIES, SINCE 1992 I HAVE BEEN ALLOWED TO PRACTICE THE ART OF PRESENTING ISSUES AND CLAIMS TO THE DEPARTMENT OF VETERANS AFFAIRS. OVER THE YEARS, IN THE OPINION OF MANY VETERANS THAT I COME INTO CONTACT WITH, A PERCEPTION EXITS THAT MEDICAL CARE IN A GENERAL SENSE, WAS NOT READILY AVAILABLE. THEY ARE OF THE OPINION THAT THE VA AS I WILL REFER TO IT HENCEFORTH, WAS ON IT'S LAST LEGS. NICKELS, DIMES, AND QUARTERS SLIPPED AWAY IT APPEARED TO MANY. BY AND LARGE MOST VETERANS FROM WW II, KOREA, AND VIET-NAM, ARE VERY CONCERNED ABOUT MEDICAL CARE IN GENERAL. THAT IS TO SAY, THE AVAILABILITY OF IT, THE QUALITY OF IT, AND THE COST OF IT. TODAY, AT LEAST IN DUTCHESS COUNTY, NEW YORK, VETERANS HAVE SERIOUS CONCERNS ABOUT VA BENEFITS IN GENERAL, DISSOLVING INTO NOTHINGNESS. THE CONCEPT THAT "WE WANT TO TAKE CARE OF YOU" COMING FROM THE VA, IS FOR MANY VETERANS, HARD TO SWALLOW. TODAY, IN A VERY BROAD SENSE, THE ATTITUDE, AT LEAST IN DUTCHESS COUNTY IS ONE OF WORRIED WARRINESS. VETERANS AND THEIR FAMILIES IN LARGE PART, BELIEVE THAT THERE IS AN UNSEEN DANGER. THEY BELIEVE THAT THE VETERANS AFFAIRS, AT LEAST WHEN IT COMES TO MEDICAL CARE, WILL CEASE TO EXIST.

PRIDE IN WHAT HE OR SHE DID DURING A PERIOD OF WAR, SEEM LOST IN A MYRIAD OF LEGISLATIVE REDUCTION TACTICS.

DUTCHESS COUNTY
OFFICE OF VETERANS AFFAIRS
CO. OFFICE BLDG.
22 MARKET STREET
POUGHKEEPSIE, NEW YORK 12601

VETERANS IN THE COMMUNITY, THAT I HOPE I REPRESENT, HAVE A QUESTION,---IF THE GOVERNMENT ABANDONS THAT VETERAN TODAY, MAY WE ABANDON OUR DUTIES AS CITIZENS TOMORROW?

THANK YOU.

Mr. SHAYS. The Service representatives agree with this committee that we would like to go and hear from participants who have attended this hearing. So they have agreed to forego any questioning.

But I would like to at least invite any of the Members if they want to respond to what they heard or just make a short comment.

Mr. GILMAN. Mr. Chairman, I would just like to thank our panelists, all of whom are out on the firing line, and for their constructive suggestions. We hope they keep doing the good work they have been doing. God bless.

Mr. SHAYS. Mr. Hinchey.

Mr. HINCHEY. Thank you, Mr. Chairman.

I'd just like to thank all of you gentlemen for your being here today, for your testimony, and for your service to the veterans' community. Thanks very much.

Mr. SHAYS. Ms. Kelly.

Ms. KELLY OF NEW YORK. Thank you, Mr. Chairman.

I want to thank, in particular, Mr. Dos Santos, about his comments about the concerns on the low-income, uninsured veterans. That's my concern, too, Mr. Dos Santos. And I think it's good that you at the State level are also as concerned as we are.

Thanks, all of you, for your work because without you, our veterans could not be as well-represented. You're doing an excellent job. Keep it up. Thank you. [Applause.]

Mr. SHAYS. Now, let me tell you how we're going to proceed. I used to be a State legislator for 13 years, and it reminds me of the hearings that we have in the State legislature.

We had a number of people who had asked to speak. I had staff draw at random from three piles. We put it into three piles: veterans, veteran service organization representatives and others, such as family members, wives of veterans, and so on.

I'm going to call three names. We're going to identify you. We're going to just have you be able to speak from where you are. You can stand in place or sit in place if you're not able to stand.

We're going to ask you to limit your remarks to 3 minutes because we're going to try to get through and hear from as many of you as possible.

If your name is called, let us know where you are, and the microphone will come to you. I understand that some people may have left. And we'll just keep going through the list. And if we go through the list that was picked, then we'll just keep going through.

The first three names in the order I'm calling is Edmund Monteleone from Clintondale. We have Ralph Karabec, Commander, Post 480, from Monroe. And we have Daniel Aversano, an LPN from Kerhankson. Now, do we have any of those three present? We're just going to invite you to—are you Mr. Monteleone?

STATEMENT OF EDMUND J. MONTELEONE, VETERAN, CLINTONDALE, NY

Mr. MONTELEONE. I am Mr. Edmund J. Monteleone.

Mr. SHAYS. It's nice to have you here, sir.

Mr. MONTELEONE. Right.

Mr. SHAYS. Thank you. You have 3 minutes. You can let him hold the mic himself. Thank you, sir.

Mr. MONTELEONE. Yes. The only complaints I have——

Mr. SHAYS. Excuse me. You know what? Let me just say this to you. I'm sorry to interrupt you, sir. This is a new experience for me. We obviously are not going to swear in our witnesses from the audience, but we transcribe this hearing. So we're going to need you to spell your—you know what? I have it in writing, and I'm just going to submit it that way. But just say your name again, and we'll mark it down. And we have it in writing. Tell us your name and your town you're from again.

Mr. MONTELEONE. I am Edmund J. Monteleone, M-O-N-T-E-L-E-O-N-E. OK?

Mr. SHAYS. Yes. Thank you.

Mr. MONTELEONE. I'm from Clintondale, 212 Rabbit Run Road, Ardonia. What else?

Mr. SHAYS. Thank you.

Mr. MONTELEONE. OK?

Mr. SHAYS. You can give us your statement, sir. Thank you for being here.

Mr. MONTELEONE. OK. I go to Castle Point. I'm from Castle Point. Now, the only complaint I have over there is that I asked the doctor to go see the dental. When I went to see the dental, I filled out the application. OK? But it's not—how can I say that—service-connected. OK?

But when I first went into the Service, there was young doctors at Camp Hood, TX that filled nine teeth within a half-hour. And I couldn't talk or eat for 2 days or 3 days. And I didn't need no teeth filled. OK? All right. That's one incident.

Now another incident I had with my teeth to go to Castle Point, and I filled out an application. They says, "No, no. You can't have that done unless you give me $125." OK? That's another incident.

I'm not saying everybody in Castle Point is not doing their job or that jobs aren't being done. But I don't like to be pushed on the side. First you can't have glasses. Then now I hear you can have glasses. Somebody's got to make up their mind over there what's what. OK? And I know a lot of fellows, a lot of people like me, are being treated the same way over there at Castle Point.

Thank you.

Mr. SHAYS. Thank you, Mr. Monteleone. [Applause.]

Do we have Mr. Karabec next? Is he here?

Mr. KARABEC. Karabec.

Mr. SHAYS. Karabel?

Mr. KARABEC. Karabec.

Mr. SHAYS. Karabec? Is it spelled K-A-N-A-B-E-C?

Mr. KARABEC. K-A-R-A-B-E-C.

Mr. SHAYS. Thank you, sir. I'm sorry I pronounced it wrong. And your community, sir?

Mr. KARABEC. No problem. That was probably my sloppy handwriting.

Mr. SHAYS. And you're from Monroe?

Mr. KARABEC. I'm from Monroe Post 48. I've been the Commander there for 7 years.

Mr. SHAYS. Well, it's nice to have you here, sir.

STATEMENT OF RALPH KARABEC, VETERAN AND COMMANDER, AMERICAN LEGION POST 480, MONROE, NY

Mr. KARABEC. Thank you. I'm also a Vietnam war vet who has been operated on, had 40 surgical procedures since I returned home from Vietnam.

This is my testimony, Ralph Karabec, before the Human Resources Subcommittee of the House Committee on Government Reform and Oversight on August 4, 1997. My personal experience with most physicians at Castle Point reflects a complete disregard for patients' welfare.

Case in point: After years of experiencing problems as a result of exposure to Agent Orange, I made a visit to Castle Point requesting an examination with a physician. After explaining my symptoms to the doctor, he made his diagnosis right from his chair without so much as a question, "You look fine to me. I don't see anything."

That was the last time I used that veterans' benefit. However, I continue to have a yearly cystoscopy for bladder cancer with my private urologist and I believe was a result of exposure to dioxins. A copy of the doctor's letter is included as part of this testimony.

After many years of annual cystoscopies and prostate exams at Castle Point, a PSA test was finally authorized which showed a 15.6 diagnosis, a well-advanced malignancy. After finding out the results of the tests done at Castle Point, I had a more specific PSA test performed by my private urologist which showed a 19.4 with a 2 percent-free PSA. Apparently the physicians at Castle Point don't even know what a 2 percent-free, what a protein-free PSA test is. I questioned them. A copy of the lab report is also enclosed as part of my testimony.

The 30 percent differential in testing could cost a veteran his life. After undergoing a radical retropubic prostatectomy on April 28, 1997, at New York Cornell Hospital—so I saved them some money—I discovered I was 0.1 millimeter of a surgical margin. A copy of the pathology report is also included in this testimony. I learned that I had the malignancy for approximately 6 years. That's after my continually going there every single year for an evaluation.

I was lucky. I managed to survive, at least for the moment. My Government not only trying to kill me once by exposing me to carcinogen herbicides, but with the lack of proper medical care and attention almost succeeded a second time. My fear now is that how many more veterans, including myself, must die due to lack of funding for appropriate medical care while the tax dollars of American patriots are sent overseas in the name of maintaining freedom. We penalize once more the very vets who fought unselfishly to keep our Nation and the world safe from tyranny, I submit.

Mr. SHAYS. Thank you very much. [Applause.]

Our third witness is Daniel Aversano. Is he here?

Mr. AVERSANO. Yes, sir.

Mr. SHAYS. Thank you, sir.

Mr. AVERSANO. Good afternoon.

Mr. SHAYS. If you could just suspend a second, I'm going to tell you the next three so they can begin. The next witness would be Cindy Trimble. Is she here? Cindy, Ms. Trimble? Anthony Buccieri.

Is he here? And also Richard—I'm not sure how to read this. Pardon me? Johannes. That's it, sir. And you're from Pleasant Valley. Thank you. You will be following.

Thank you. Sorry to interrupt you.

Mr. AVERSANO. Good afternoon.

Mr. SHAYS. Good afternoon.

STATEMENT OF DANIEL AVERSANO, LPN, VETERAN AND CASTLE POINT EMPLOYEE, KERHANKSON, NY

Mr. AVERSANO. My name is Daniel Aversano, and I work at Castle Point VA. I've been there for 10 years. I'm an LPN. I'm also a Vietnam vet. And I've also been taken care of by Castle Point, and they have been very good to me. Since being there, I've made a lot of good friends—Korean vets, Vietnam vets. And Castle Point I think is a very good place to work, and we try very, very hard to take care of our vets.

Just one thing I'd like to put on the floor as something to think about: Why is it warranted to use the Vassaro R and shipping our Castle Point patients over there when we closed our abilities to operate at Castle Point? Does that giving—why wouldn't it be smarter to give our staff the money and keep our vets at home, where we have done such very good care for many, many years? Why is that cost-effective? That's just something that I just can't understand.

And I want to thank everybody for coming out today, and I'm very proud to work for Castle Point VA. [Applause.]

Mr. SHAYS. Thank you very much.

Ms. Trimble.

STATEMENT OF CINDY TRIMBLE, FAMILY OF DECEASED VETERAN, GANHAM, NY

Ms. TRIMBLE. Good afternoon.

My name is Cindy Trimble. My grandfather died as a result of a lack of treatment at Castle Point VA Hospital.

The short of the story is he was admitted on March 24 with a so-called "virus." Two weeks later, when his condition had deteriorated to a point where the family could no longer just sit idly by and wait for Castle Point to take some type of further action, we had him transferred to Hudson Valley Hospital Center. That was a difficult task. We met with much resistance from the doctor, but we were able to get him down there after contacting the Acting Chief of Staff.

When he arrived at Hudson Valley Hospital Center, within 1 hour of his arrival, the diagnosis was a perforated ulcer. They took him in for immediate surgery, but he died 2 days later as a result of the preexisting infection that set in. Some of you may be familiar with the term "sepsis." They found bacteria and acid in his blood that had been an ongoing condition as a result of the perforated ulcer not picked up at Castle Point.

I only have 3 minutes. So, in closing, I just had a couple of things I'd like to add. Earlier our panel was talking a lot about statistics and surveys and things like reducing bed days of care. I'd like to ask if the death rate, the statistics on death, the mortality rate, is inclusive of those deaths that occur outside of the hospitals, but re-

sult from the care received in the hospital, like deaths that occur at home or after a patient is transferred to another hospital.

I'd also like to respond to an earlier statement made by Mr. Farsetta about surveys. My grandfather did receive a survey a few days after he died.

And, finally, I'd like to say that under the category of reducing bed days at Castle Point, we were never able to contact a physician during my grandfather's care at Hudson Valley Hospital Center. When we did, he was very annoyed with us. And he told us that they—I don't know who "they" are, but I assume he meant the Department of Veterans Affairs—were on his back to get my grandfather out of the hospital, that they wanted him out because they needed the bed.

So I just wanted to add that as perhaps some type of proof that there is a push to clear these patients out. And I do think that while there may be some good care at these hospitals, I think the VERA budget funding cuts are being used as a crutch.

And I'd like to thank Maurice Hinchey, Ben Gilman, and Sue Kelly for anything they can do on behalf of the veterans and their families. Thank you. [Applause.]

Mr. SHAYS. Thank you. Thank you, Ms. Trimble. I believe you're from Ganham? Yes. Thank you.

Anthony Buccieri. And you're from?

Mr. BUCCIERI. I am from Newburgh, NY.

Mr. SHAYS. Yes, sir.

STATEMENT OF ANTHONY BUCCIERI, VETERAN AND VETERANS OF FOREIGN WARS AND DISABLED AMERICAN VETERANS, NEWBURGH, NY

Mr. BUCCIERI. I'm a veteran of World War II, a recall for the Korean war. I'm a veteran at the VA hospital at Castle Point. I have been there as a volunteer for over 8 years. I've seen many changes at Castle Point, some for the good, some not so good.

But I'd like to call out I've sent in reports to the District Commander of the Veterans of Foreign Wars. This was dated back in March. I also sent information to the local papers in our area, six of them in general. Out of six papers, only one published what I had to say.

In regard to the deaths at Castle Point, when all of this broke out in the newspapers, I took a quick survey, picked up all the papers, and I found that out of the 12 hospitals in our immediate area, there were 35 deaths and only one at Castle Point.

I'd like to explain one thing that many people—and I've got these personal calls, even at night, from veterans' families, "Can you get my father" or "my brother" or "my uncle into Castle Point?"

I went out of my way, which I didn't mind doing, asked these people, "Are they registered with the VA hospital? If they aren't, we'll give you an application. Fill it out. Get a hold of your doctor, the hospitals from both sides. And try to get that patient into Castle Point," which they did.

The reason for going into Castle Point VA Hospital was that the limitation on the stay in the hospital, whether it's Medicare or private insurance, was the cause for these patients being transferred to VA hospitals.

They were not completely cured in a matter of months or days or even a year. Some of them did pass away, unfortunately, but many of them were cured or they had a longer hospital stay. That's in regard to the mortality rate.

As far as the patients being taken care of at Castle Point and as a volunteer there 2 days a week, about on the average of 7 hours a day, I found that the staff has been overworked to a point. But, as was stated before, they are doing the best job they can with what they have. The fact that the funding has been cut, the staff has been cut, they are doing a good job.

In regard to a few other details, I'd like to submit these as evidence to you. I don't want to take up too much time. Basically the VA is there for veterans and veterans only. And it's been there at Castle Point for 72 years. And I've been a patient in the hospital as well as a veteran and as well as a volunteer.

I thank you.

Mr. SHAYS. Thank you, sir. [Applause.]

Richard Johannes from Pleasant Valley?

Mr. JOHANNES. Yes.

Mr. SHAYS. Sir, before you begin, let me just tell the next three speakers. We have, I think it is, Al Datlolo. Am I saying the name correctly? The second witness would be Paul Davidson. And the third would be Gloria Wood. Do we have those three? OK. Am I saying this right? This is Datlolo. Mr. Datlolo?

So yes. Thank you, Mr. Johannes.

STATEMENT OF RICHARD JOHANNES, VETERAN, PLEASANT VALLEY, NY

Mr. JOHANNES. Good afternoon. My name is Richard Johannes. I'm a Vietnam veteran. I served over 5 years in the U.S. Army. And two of those were in Vietnam. All I knew was that if I ever needed health care later on in life, the VA was supposed to provide it for me.

With Castle Point, over the last year, I feel that everything has just gone downhill. They changed us to the blue team and the green team. You get a doctor. First of all, I don't even think he understands half of what I say. OK? [Applause.]

And when I do try to tell him the different problems I have, I'm 100 percent Service-connected. OK? They put it down for PTSD only because it's a simple way to shuffle me off to one side.

You go there. You get there early like they tell you to, a half an hour, an hour before. You go into your clinic. It ends up you're 39th on line already, and it's only 8:30 a.m. They've got six seats in the place. And you sit there or hang around outside until somebody takes care of you. Then you have to run to your next appointment.

By the end of the day in 1 day when the doctor was supposed to take all the information that was done, blood work, ultrasound, EKG, and all that other good stuff they have to do to me, he didn't have the information in his computer. So he says, "Well, if it's not really bothering you, don't worry about it."

And I'm going, "Hey, I've had this pain on and off for 6 months."

He says, "I'll get in touch with you when I get the results back." Well, that all happened in April. It is now August. And I haven't heard one single word. OK? And that's just one instance.

You try to get glasses there, you have to sit and wait for 2 to 3 months to get a pair of glasses. I can go down the street to any mall and get a pair of glasses in an hour.

I needed a crown for a tooth that somebody finally figured out needed to be rectified since Vietnam. Well, it took them 3 months to make a crown.

I can't understand this, you know. Yes, they're supposed to be moving into the computer age. But when it comes to simple things like glasses or new crowns or having even your teeth worked on, they have a hard time doing these things.

And the attitude down there to me is just unbelievable. They don't care. And I wish they would get some doctors in there who speak American and understand American. [Applause.]

And that's basically all I have to say. Tomorrow I will wander my way over again to the VA and ask them, "Have you finished and come up with the results?"

And I can guarantee you what the answer is going to be, "We can't find the files" because they already did that twice this year.

Thank you very much for your time.

Mr. SHAYS. Thank you very much. [Applause.]

We'll be going to Mr. Datlolo, then Paul Davidson, and then Gloria Wood. Is Mr. Datlolo here? He's not here. So we'll go to Mr. Davidson. Is he here? OK. And then Gloria Wood. Is Gloria Wood here?

Ms. WOOD. Yes, I am.

Mr. SHAYS. Thank you, Ms. Wood.

STATEMENT OF GLORIA WOOD, WIFE OF VETERAN, PINE BUSH, NY

Ms. WOOD. I'm speaking on behalf of my husband, who happens to be partially disabled.

In January 1995, we, unfortunately, had an accident on our way to Florida. And he fell going into a motel. Six weeks later and two operations, in a private hospital, for his hip, I was told, "Take him home. Put him in a nursing home. He'll never walk again."

I couldn't find a nursing home as quickly as I wanted. So, in desperation, I will say, I said to my daughter, "Call up Castle Point and see if he can get in because he is 40 percent disabled."

They immediately took him in. Ten days later, he was walking on parallel bars. He was there for 6 weeks. He has continued to take therapy, and we have nothing but good things from Castle Point. And I think it's nice to know that there are some of us who do appreciate it.

Thank you.

Mr. SHAYS. Thank you, Ms. Wood. [Applause.]

We appreciate your words of appreciation. And I have you down from Pine Bush?

Ms. WOOD. Pine Bush.

Mr. SHAYS. Thank you.

Our next three witnesses: Jerry Blumenthal from Middletown, Daniel Morea from Beacon, and Helen Janiszewski. Am I saying that name right? Janiszewski, also from Middletown.

STATEMENT OF JEROME BLUMENTHAL, VETERAN, MIDDLETOWN, NY

Mr. BLUMENTHAL. I thank the committee for listening to me.
Mr. SHAYS. You are Mr. Blumenthal?
Mr. BLUMENTHAL. Yes, B-L-U-M-E-N-T-H-A-L.
Mr. SHAYS. A-L. I'm sorry. And it's from Middletown?
Mr. BLUMENTHAL. Middletown, NY.
Mr. SHAYS. Thank you, sir.
Mr. BLUMENTHAL. I thank you for listening to me. This will be short.

There's one thing I can't understand. Somebody mentioned it. One of the people who spoke mentioned it. How come we can investigate things up to the sky, investigate things that spoil people's lives, investigate everything? How could we go with the VERA without investigating the VA's administrative statements? [Applause.]

How could we make a decision to cut funds or to take these funds away from our areas before we really knew what could happen to our veterans? I would like that question answered.

Thank you. [Applause.]
Mr. SHAYS. Is Daniel Morea here?
Mr. MOREA. Yes, I am, sir.
Mr. SHAYS. I'm sorry. Where are you?
Mr. MOREA. I'm right back here, sir.
Mr. SHAYS. Thank you very much, sir.
Mr. MOREA. You're welcome.
Mr. SHAYS. And you're from Beacon?
Mr. MOREA. I'm from Beacon, NY.

STATEMENT OF DANIEL MOREA, VETERAN AND ASSISTANT SERVICE OFFICER, DEPARTMENT OF NEW YORK AMERICAN LEGION, NINTH DISTRICT REHABILITATION CHAIRMAN, AMERICAN LEGION, BEACON, NY

Mr. MOREA. I'm an assistant service officer for the Department of New York American Legion as well as the Ninth District rehabilitation chairman for the American Legion.

I would like to thank the chairman and the distinguished members of the subcommittee for allowing me to testify today. The testimony so far given today has been more than interesting. It has brought to light both what we have heard from the subcommittee as well as what we have heard from the audience. The action that follows will be even more interesting.

The American Legion appreciates the opportunity to share our views on the quality of health care provided by the Department of Veterans Affairs. Mr. Chairman, there are several concerns with regard to the VA's ability to continue to provide quality health care.

Although the American Legion will defer any definitive or evaluative comments until completion of a site visit to the Veterans Administration Hudson Valley Health Care System, which is scheduled on August 19 and 20 of this year, we are, however, prepared to address the specific issue at hand: those concerns raised regarding the increased mortality rate and morbidity rates at Castle

Point and Montrose VA medical facilities, now referred to as the Hudson Valley Health Care System.

The VA has undergone significant reorganization in the past 2 years, realigning its field operations from a system of 172 independent medical facilities within 4 geographic regions to a system of 22 Veterans Integrated Service Networks, called VISNs. The VA Hudson Valley Health Care System is a component of VISN 3 which encompasses the VA northern New Jersey Health Care System and each of the medical centers in New York metropolitan area.

Each VISN has been granted certain latitude in how it chooses to deliver health care services to veterans in its primary service areas. While there are substantial differences among these emerging networks with regard to how, when, and where health care services will be provided, VA headquarters has established a number of performance measures to assure accountability along with increased empowerment, as we have already heard testified to today.

VISN 3 has adopted an integrated delivery system model based on network-wide care lines. Simply put, veterans who in the past relied on a single Veterans Administration medical center to meet all their health care needs are now considered network patients. As network patients, all of their health care will be managed by a primary care team located in close proximity to where they reside. That was the premise of VISN. That's not what we have heard today.

However, as need for specialty care arises, veterans will find the entire consortium of VA health care facilities within VISN 3 responsible for meeting their complete medical needs. As a result, the VA Hudson Valley Health Care System has been designated as a center for excellence for the network in the areas of geriatric, extended care, and mental health care.

It seems that since the time of this transition, mortality and morbidity rates have increased, creating a groundswell of concern for many constituents and an increase in media coverage.

As members of this committee may know, the purpose of realignment was largely in response to the VA's need to become more cost-efficient in the delivery of services. Furthermore, VISN 3 was identified as the most expensive network in several key financial performance measures, including total cost per veteran.

All of these facts combine to create an emphasis on reducing costs. Underscoring this need is the Veterans Equitable Resource Allocation, VERA, and its methodology. We believe that the initiatives to improve efficiency——

Mr. SHAYS. Mr. Morea.

Mr. MOREA. Yes?

Mr. SHAYS. Can I just interrupt you a second?

Mr. MOREA. Sure.

Mr. SHAYS. I need to be somewhat consistent on the 3 minutes. Are you going to be completing——

Mr. MOREA. I am just about done, sir.

Mr. SHAYS. Thank you.

Mr. MOREA. You're welcome.

We believe that the initiatives to improve the efficiency are in the best interests of veterans everywhere; however, not at the expense of accessing quality, which may be in jeopardy in some areas where the budgets have been cut back.

The American Legion has proposed a GI bill of health in an effort to enhance and ensure quality VA health care for the future by opening the system to all veterans and their families currently not eligible for care on a premium basis.

We have scheduled a meeting with the VISN 3 director, Mr. James Farsetta, on August 22, immediately following the upcoming site visit. Presently the American Legion accepts the VA's explanation that the rising mortality rates at Castle Point are attributable to the decline in the number of inpatient beds and the increase in referrals from other VISN 3 medical facilities of the most chronic patients. However, should any concern arise as a result of the upcoming site visit, they will most certainly be included in a subsequent report for distribution to congressional Members whose districts overlap or are within the boundaries of the veterans, VISN No. 3.

The site visit will also focus on inpatient of VERA as potentially creating the scenario in which changes may occur too rapidly without the benefit of adequate planning on the horizon.

The American Legion will also evaluate VERA's impact on specific specialty programs, such as post-traumatic stress disorder, chronic mental illness, and long-term care, particularly as the budget relates to capacity.

Finally, we also will examine the most current customer service course as well as the networks' adherence to the VA's other stated performance measures.

Mr. Chairman, this concludes our statement, and we thank you for your time, sir.

Mr. SHAYS. Thank you, sir. [Applause.]

The next three witnesses: Helen Janiszewski from Middleton, I think, Middletown; Philip Schiffman from Washingtonville; and Jane Kowal from Port Jervis. Do we have—is Helen here? Sorry. Good try. You must be a Marine. She's not here.

Are you Philip Schiffman? Mr. Schiffman, thank you. And you're the State Commander? Thank you, sir.

Mr. SCHIFFMAN. Thank you, Mr. Chairman, members of this subcommittee.

STATEMENT OF PHILIP SCHIFFMAN, VETERAN AND NEW YORK VFW, WASHINGTONVILLE, NY

Mr. SCHIFFMAN. Thank you for the opportunity to testify today on behalf of the 110,000-plus members of the Veterans of Foreign Wars Department of New York on the very important issue of health care our Nation's veterans are receiving in the Department of Veterans Affairs' medical centers, particularly the medical centers at Castle Point and Montrose. Thank you also for conducting this hearing to help you get to the bottom of the allegations made about quality care issues.

First and foremost, let me state loud and clear that the VFW Department of New York is appalled at recent newspaper reports de-

picting quality of care issues and high mortality rates at these facilities.

Our veterans deserve better. We at the VFW will not tolerate this type of treatment of our Nation's former defenders. We call on you, our elected officials in Washington, to fully investigate these reports and hold these VA officials accountable who are responsible. Today and future such hearings must get to the bottom of the situation.

The numerous allegations of insufficient and quality care issues made in local newspapers by veterans, families of veterans, VA employees, and VA volunteers point to the serious problems at these two facilities. There obviously was a lack of management at both the local and network levels that allowed these situations to occur.

I sincerely hope VA has now corrected the deficiencies. I know that VFW officials and members who have visited both Castle Point and Montrose in recent days have told me that the facilities are clean and everything seems to be fine. Not being a health care professional, I cannot determine if, in fact, all is now well.

Some have blamed the incidents depicted in the newspapers to be caused by the Veterans Equitable Resource Allocation system, VERA, which we have heard a lot about today. VERA is definitely the cause of the shifting of dollars from the Northeast and Midwest to the Southern and Western States. However, management at the facilities and network management have told the Veterans of Foreign Wars on more than one occasion that money is not the problem.

If money is not the problem, then it is obvious to me that the cause of our problems were inadequate and inefficient management coupled with our aggressiveness of network management to trim too much too fast from the budget of these facilities. Quality control mechanisms definitely were not in place. And local as well as network management were not paying attention to details.

It is my understanding that a new management team is being named for the facilities, people have been transferred or who have left VA employment. And the VA Medical Inspector is doing a complete review of both facilities, which they do not anticipating completing until the end of this summer. I also understand that additional staff have been placed in various critical areas of these facilities.

With all said and hopefully done, VA has a major public relations problem to win back the full confidence of the veterans of Hudson Valley. Openness and being truthful to veterans and their families and, yes, to Members of the U.S. Congress would be the first step in the right direction.

We, the veterans of Hudson Valley, should not hear from newspapers of a closing of surgical units, possible staff reductions, and the quality of care issues. Faculty and network management need to be the ones to tell us.

Mr. SHAYS. Thank you.

Mr. SCHIFFMAN. One more second. We understand that the delivery of health care is changing and that the VA must also change, but when we hear about issues in the newspapers, rather than VA officials, their intentions become suspect.

The VFW is the greatest supporter the VA has throughout this Nation and in Washington, DC. We feel that the VA health care system is the top-rate deliver of health care to our Nation's veterans. However, the system cannot operate without proper funding and without proper management, both of which seem to have contributed to the instances noted.

Thank you for the opportunity to address you today. We of the VFW look forward to working with you and with the VA to resolve issues addressed today and to do our utmost to help turn public opinion around about the quality of care our veterans receive in Castle Point and Montrose VA medical centers. Thank you very much. [Applause.]

Mr. SHAYS. Thank you very much.

Mr. Schiffman, I'm going to insert into the record because you focused in on the newspaper article, and I will tell you the committee will be examining this document. It's from the Department of Veterans Affairs, Veterans Health Administration, VISN 3, the white paper on news articles about a VA Hudson Valley Health Care System.

I'm going to read the first paragraph and the next sentence of the second paragraph, and then I'm going to submit those numbers, just to say. It said,

Issue: On Tuesday, May 13, 1997, a newspaper article about the VA Hudson Valley Health Care System appeared in the Times-Herald Record, a Dutchess County, New York newspaper. It alleged that since the Veterans Equitable Resource Allocation, VERA, budget cuts occurred in New York, the mortality rate at the Castle Point facility had doubled and at the Montrose facility had increased 80 percent. Congressional representatives have expressed their concern patient care is suffering because of VERA.

Facts: A study of the mortality rate at VA Hudson Valley reveals there is no evidence of an increase in deaths at the two facilities. In reviewing the combined death rates, there is little or no fluctuation.

These are the death rates that they have during the times cited: October to March 1995, the number of deaths: 121; October-March 1996, 109; October-March 1997, 123. And then they do it based on the number of deaths per hundred. There is a slight increase in the Castle Point number of deaths per hundred.

But the document submitted to this committee is far in disagreement with the article that you have referred to. It does not in any way call into question the concern about VERA. It doesn't call into question about the concerns of this committee. But it does state emphatically that what you read in the newspaper is just simply not true. And we will look into that, I can assure you. Thank you.

[The information referred to follows:]

DEPARTMENT OF VETERANS AFFAIRS
VETERANS HEALTH ADMINISTRATION
VISN 3

WHITE PAPER ON NEWS ARTICLES ABOUT VA HUDSON VALLEY HEALTH CARE SYSTEM

Issue: On Tuesday, May 13, 1997 a newspaper article about the VA Hudson Valley Health Care System appeared in *The Times Herald Record*, a Dutchess County New York newspaper. It alleged that since the Veterans Equitable Resource Allocation (VERA) budget cuts occurred in New York the mortality rate at the Castle Point facility had doubled and at the Montrose facility had increased 80%. Congressional representatives have expressed their concern patient care is suffering because of VERA.

Facts: A study of the mortality at VA Hudson Valley reveals there is no evidence of an increase in deaths at the two facilities. In reviewing the combined death rates there is little or no fluctuation. The article also did not consider the missions of the two facilities: Castle Point providing primary and secondary care, including inpatient medical care and Montrose providing primary care and mental health care, particularly long-term psychiatric care. In addition over the past year more care is being provided on an outpatient basis and the patients who are admitted for care are those who are most acutely ill. Beginning in December 1996 acute medical patients were sent from Montrose to Castle Point for care.

From January 1, 1996 to April 29, 1996 there were 58 deaths at Castle Point; not 36 as reported in the news article. From January 1, 1997 to April 29, 1997 there were 71 deaths at Castle Point, 10 of them being patients who transferred from Montrose. In short, deaths of patients who originated at Castle Point were 58 during that time period in 1996 and 61 during the same period in 1997. The newspaper failed to accurately compare the data and published an erroneous graph which claimed to show the increase in deaths at Castle Point only when in fact it shows deaths of Castle Point patients for a six-month interval compared to the deaths of Castle Point and Montrose patients combined. The graph also begins at October 1996 which is one of the months in which the lowest number of deaths has occurred at Castle Point in recent years. The story is more accurately portrayed by looking further back in time.

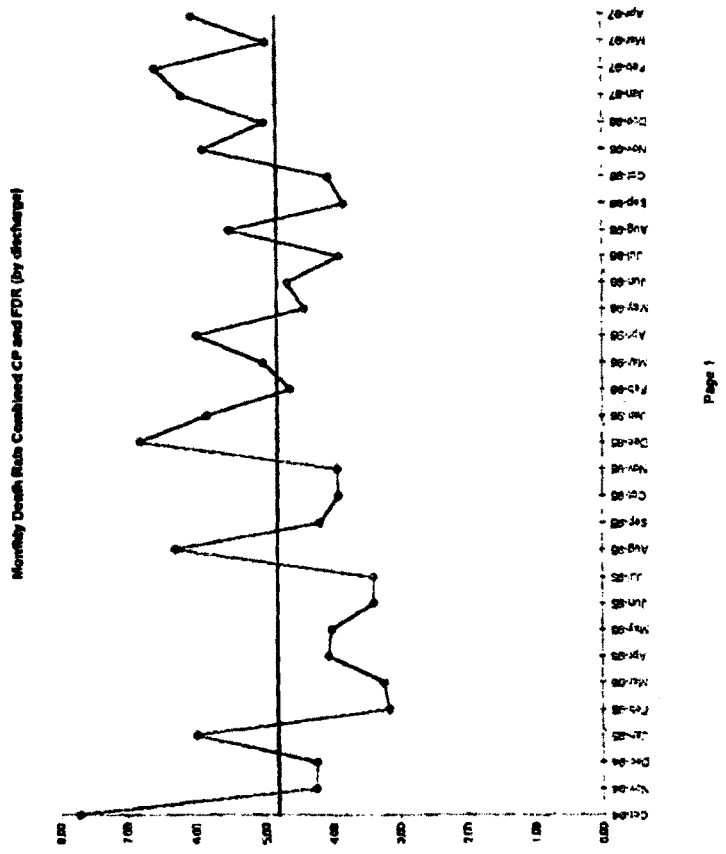
An analysis of the number of deaths and the mortality rate per discharge at VA Hudson Valley over the past two and a half years reveals marked monthly variability. A comparison of the number of deaths during the first two quarters of Fiscal Years 95, 96 and 97 is as follows:

Time Period	Number of Deaths
Oct-March FY 95	121
Oct-March FY 96	109
Oct-March FY 97	123

The mortality rate per 100 discharges for the first two quarters of Fiscal Years 95, 96 and 97 is as follows:

	Mortality Rates		
Time Period	Castle Point	Montrose	Combined
Oct-March FY 95	8.27	2.17	4.74
Oct-March FY 96	9.27	2.20	4.93
Oct-March FY 97	10.90	2.58	5.39

Therefore, the mortality rate over the three-year period changed less than fourteen percent. The attached graph shows the mortality rate per 100 discharges per month from October 1994 to April 1997.


Monthly Death Rate Combined CP and FDR (by discharge)
Page 1

PERIOD	FDR DEATHS/ DISCH.	FDR RATE	CAST PT DEATHS/ DISCH	CAST PT RATE	FDR+CP DEATHS/ DISCH.	FDR+CP RATE
OCT - MAR FY95	32/1479	2.17	89/1078	8.27	121/2554	4.74
OCT- MAR FY96	30/1361	2.20	78/852	9.27	108/2213	4.93
OCT- MAR FY97	39/1513	2.58	84/771	10.90	123/2284	5.39

In Castle Point, although the absolute number of deaths has not increased, the rate has increased. This is due to the fact that we are discharging fewer, most likely due to the fact that we are now admitting only the most sick patients who have a higher mortality probability.

Mr. SHAYS. At this time is Jane Kowal here?

Ms. KOWAL. Right here.

Mr. SHAYS. Thank you. Nice to have you here.

Ms. KOWAL. Thank you. Thank you for having me. Please bear with me. I get very emotional.

Mr. SHAYS. Does that just mean with all of these other veterans you get emotional?

Ms. KOWAL. Well, maybe.

Mr. SHAYS. OK. Thank you.

STATEMENT OF JANE KOWAL, DAUGHTER OF DECEASED VETERAN, PORT JERVIS, NY

Ms. KOWAL. I'm Jane Kowal. My father was Carl Irwin. He was a veteran, and he had gone to Castle Point for a hip operation.

As you know, they sent him and all operations to the Bronx. He went through the surgery fine, came back to Castle Point about the 17, I believe, of February. Two days later, he's in ICU. I don't know what happened. I know there are times you do develop pneumonia when you break a hip. But this seems so sudden. OK.

We rushed there. He has a feeding tube. The man did at times need help to feed himself. OK. At the nursing home, he had signed a health proxy, "No CPR. And, please, no artificial feeding." I thought being a VA-approved nursing home that these documents would be carried over to Castle Point. I guess I was wrong or ignorant to think that.

Anyway, I asked about the feeding tube. I did not get any answer. I had asked about medications, "See the doctor."

Well, that was a joke. I could not find his doctor, "He's not in this building," "He's on the floor." You name it, I got it. Finally, I did get someone.

My father was getting worse. He was a 195-pound man going down to, he ended up, 173 in 17–18 days. I wanted to know what was going on. A man answered the phone. He said, "What do you want?"

I said, "I want to talk to someone about my father." He never told me who he was. I don't know if he was the doctor. I said, "I don't understand the feeding tube. I don't understand if there's a problem with his heart. I know about the pneumonia. He has sugar."

And they said, "Well, his heart's feeding." And that was that.

I was very upset. I got a hold of my sister. She carried on, finally got his regular doctor in, who we later found out was on vacation. She did her best to bring him back, but it was too late. On March 3, he died. He died of a broken hip. Do you believe this?

I believe in my heart I misguided my trust in the VA system. In the times in the past, we trusted you. You were very good. You were always there for us. There was no doubt about it. But due to these cuts, my father is dead. And I don't know how to take care of this in my heart, in my mind.

Thank you.

Mr. SHAYS. Thank you, Ms. Kowal.

I am having a hard time reading the signature. I think it's Anthony Bamonch. Is it close? It's from Clintondale. Mr. Bamonch is from Clintondale? He's gone? OK. Raymond Moonan? Is Raymond

Moonan here? OK. And then Dorothy Mianti? Is Raymond Moonan here?

Mr. MOONAN. Yes.

Mr. SHAYS. Thank you, Mr. Moonan. You're from New York and Florida both?

Mr. MOONAN. Sir?

Mr. SHAYS. It says Florida here. Is that your mailing address?

Mr. MOONAN. I'm from Florida, NY.

Mr. SHAYS. OK. I love it. Remember now, I may be a Member of Congress, but I am from Connecticut. So don't go back to your home and say, "This idiot didn't even know there was a Florida." [Laughter.]

I had never heard of Florida, NY. I apologize.

Mr. MOONAN. The home of Seward, who purchased Alaska.

Mr. SHAYS. OK. Your time starts now.

STATEMENT OF RAY MOONAN, VETERAN AND DISABLED AMERICAN VETERANS AND AMERICAN LEGION, FLORIDA, NY

Mr. MOONAN. My question is last week the House approved 346 to 85 the conference report on a bill to reduce entitlement outlays by more than $135 billion in 5 years by slowing Medicare, Medicaid, spending growth, restraining mandatory spending in the areas of housing and veterans' benefits, agricultural subsidies, vocational education, along with separate bills cutting taxes for families with children, education, and investors in business and others. My question is: Why are we lumped in with the farmers? [Applause.]

Mr. SHAYS. Why are you lumped in with the farmers?

Mr. MOONAN. Why are we lumped in with the farmers? We're veterans. You're voting to cut veterans' benefits along with cutting subsidies to the farmers and business.

Mr. SHAYS. I'm not going to respond to every question because in some cases I don't know the answer and I will find the answer, and that's the purpose of these hearings.

But, sir, there are two points. One is that the money allocated to the VA may have been reduced because it didn't take into consideration additional money that now can be collected from Medicare. And there was a dialog between two Members, a Republican and Democrat, Cliff Stearns and the gentlelady from—New York or Michigan—to verify that it is the intent of Congress that there will be no cut. The question is just making sure that for the first time the VA can collect Medicare money. And, therefore, you don't need to——

Mr. MOONAN. This is not happening, sir.

Mr. SHAYS. No. It's just starting now.

Mr. MOONAN. That's a subvention experiment in about three areas. It's not affecting New York people.

Mr. SHAYS. No. The other issue—and this relates to the whole question of VERA—is there is a reallocation of resources. Some States, some areas are getting more. And some States, like New York and Connecticut, are getting less. And that's the issue we are addressing today, understanding why we're giving more in one area to the detriment of an area that is getting a lot less. And in the

shift is too much going too quickly, and the very valid question, which we'll get an answer to and hopefully change.

Mr. MOONAN. What I'm saying is $135 billion is going to be taken from these entities for a period of 5 years. Now, this is going to affect veterans. For 5 years, there are going to be cuts. And this was last week. Last week this was done. And here we are today talking about doing things for veterans, and we're not doing them. We're just talking. [Applause.]

Thank you.

Mr. SHAYS. Thank you, sir.

Dorothy Mianti, is she here? James Catania from Walkill; Colleen Mussolino from Brooklyn; and Paul Davidson. Is James——

STATEMENT OF JAMES CATANIA, VETERAN, VFW AND AMERICAN LEGION, WALKILL, NY

Mr. CATANIA. First I want to thank you gentlemen for letting me voice my opinion. I have something to say that Congressman Maurice Hinchey might remember and, then again, he may not because I wrote him a letter of my case. And he sent it to Washington. And I got a letter from Washington last week referring me back to Congressman Hinchey.

I went to Castle Point 3 years ago for a hearing aid. I had quite an extensive examination. And the doctor said, "Mr. Catania, I'm going to send you down to Bronx because they have bigger and better machinery than we do, and you can get a better examination than we can give you up here."

So the next morning I got on the bus, went down to the Bronx, went for an examination. I waited about 4 hours, from about 11:30 until about a quarter to 4. And I had my examination. And he said to me, word for word, "Mr. Catania, I'm going to send you back to Castle Point because they've got bigger and better machinery than we have and they can give you a better examination than we can." [Laughter.]

I said, "I beg your pardon?" And he repeated it. So I said, "All right." And he gave me a prescription. So I went down to the pharmacy to get the prescription filled, and there were about *X* number of men waiting to get their prescriptions filled. And my bus was leaving in about 10 minutes. So I left.

I went to the pharmacy at Castle Point, and they refused to honor that prescription. They said, "We can't do that here. You've got to take it down to the Bronx."

So I got a hold of the service officer, and he got around. He got a hold of the doctor that finally made out the prescription and gave me the prescription I wanted.

And I, for one, think that that is one of the reasons that there's a saying "Use it or lose it." And I think that is one of the reasons why we lose beds at Castle Point, because people go through the same thing that I went through, maybe not for the ears but for something else, and they say, "Well, I'm not going back there anymore." I haven't been back in 3 years because I lost faith in the VA.

That's my story, and I thank you very much for listening.

Mr. SHAYS. Thank you very much. [Applause.]

Colleen Mussolino from Brooklyn.

STATEMENT OF COLLEEN MUSSOLINO, VETERAN AND NATIONAL VICE COMMANDER, WOMEN VETERANS OF AMERICA, BROOKLYN, NY, ON BEHALF OF MONTROSE WOMEN VETERANS OF AMERICA

Ms. MUSSOLINO. Yes. Thank you.

I'm Colleen Mussolino. I'm the national vice commander for Women Veterans of America. We have a chapter up in the Montrose VA, and I was contacted and asked to speak on their behalf, especially of the women veterans, as a national issue.

Women only began to get their benefits in 1973. So we're still trying to play a catchup game with you men. OK? We have very little facilities for women. We have gynecologists, but it's taken a long time to get there. You could get a penile implant before you could get gynecology. OK?

One of the other problems is that there is a lack of beds and services in the VAs. What used to be three beds of private rooms for women are now done to one bed and possibly sharing with a man. OK? We share the bathrooms. We share the showers. We have to have armed guards stand outside. I mean, this is ridiculous.

These cutbacks have made it worse. We're trying to get entitlements, and we're getting pushed back further and further and further. And in Montrose VA, there was supposed to be a women veterans coordinator, as there is in all of the VAs, has not been replaced. It's been now over a month. There is no women veterans coordinator at all for these women to go to to take their problems, to take their gripes. OK? They're told that they have to go to Castle Point.

That's not acceptable. It's not acceptable by my organization, and it should not be acceptable by any veterans' organization that they should have to travel back and forth or to make calls back and forth to get issues taken care of.

The other issue that I have is in the fact of women being put into situations where they have been put in with men in various different areas. And these are women that have been raped. These are women that have been sexually assaulted. And they're put into areas where they are not protected.

And the people are not assuming that women have gone through these assaults. It's unfortunate that the statistics are so high that you have to assume today that 9 out of 10 women have been sexually harassed or assaulted. These statistics are extremely high. And then you put women in where we've got to put into areas where we are being jeopardized. That is wrong.

Another issue is the fact is that we are tired of being "yes"ed to death. Every time we make a complaint, it's a valid complaint, but we are tired of the people just saying, "Yes," "Yes," "Yes." And I know from Mr. Sabo and Mr. Farsetta from Brooklyn when they were the directors there. I have gone and met with them, asked them questions, and we got "yes"ed to death.

Thank you. [Applause.]

Mr. SHAYS. Thank you.

Our next three witnesses are: Thomas O'Connor; Gerard Kelly from Jackson Heights; and Daniel Reilly from Beacon. Do we have

Mr. O'Connor from Marlboro? Right there? And then we'll go to Mr. Kelly, and then we'll go to Mr. Reilly.

STATEMENT OF THOMAS O'CONNOR, VETERAN AND NURSE MANAGER, OUTPATIENT SERVICES, CASTLE POINT, MARLBORO, NY

Mr. O'CONNOR. Good afternoon. My name is Tom O'Connor. I am a Vietnam veteran. I am a public servant at Castle Point and the nurse manager in outpatient services.

I've heard it said that you shouldn't take on anybody who buys their ink by the barrel, but I do have to ask that—it seems to be a conflict of interest that the organization of the newspaper in question that's been trying to bury Castle Point, the Times-Herald Record. If they're successful in what appears to me as an employee in their attempts to bury the hospital, one of the main beneficiaries is going to be their largest advertisers.

Every Sunday, I open the paper, and there's page after page of hospital advertising. I noticed that they seem free to take on Castle Point and throw a lot of dirt because we're not an advertiser. If we go down, if our patients have to seek out services elsewhere, they're going to seek out those services with the advertisers that advertise with them. That's a point relative to advertising.

Another point is I understand a lot of our patients do not want to travel from one hospital to another. To put it in another context, if I were to go to Horton Hospital and my doctor were to call me in and see that I needed a hip replacement and said, "Tom, I'll tell you what. I want you to get the finest of care. What I'm going to do is I'm going to send you down to the hospital for special surgery which happens to be one of the most highly-rated orthopedic institutions in the country," I would go home and tell my friends, "What a great doctor I have. He cares so much that he's going to send me to get the best care."

Meanwhile, back at the ranch, at Castle Point, if we refer a patient to the Bronx VA, where they receive care from surgeons who are affiliated with the hospital for special surgery, somehow we're accused of giving second-rate care, why we can't provide it. I'm at a loss why the two different judgments. If I worked at Horton, I'd be a hero. If I work at Castle Point, I'm a devil.

That's all. [Applause.]

Mr. SHAYS. Mr. O'Connor, thank you very much for giving us your position on that.

Ms. MUSSOLINO. Excuse me?

Mr. SHAYS. Yes.

Ms. MUSSOLINO. Could I just take a second? I just noticed the man just decided to stand next to me. I have no problems with my father going for hip surgery at the Bronx. I have a problem with the cuts that when he came back, he was not able to feed himself. And they stuck a tube down him. And now we have a group called the Silver Spoon to volunteer and feed these men. This is what I have a problem with.

If he gets special care and better treatment elsewhere, fine. But we should be able to have that here. That's all. [Applause.]

Mr. SHAYS. Mr. Kelly is over here. Do you have a mic, sir?

Mr. KELLY. Yes. Thank you.

Mr. SHAYS. Thank you.
Mr. KELLY. Thank you.

STATEMENT OF GERARD KELLY, VETERAN AND EASTERN PARALYZED VETERANS ASSOCIATION, JACKSON HEIGHTS, NY

Mr. KELLY. I'm Jerry Kelly from the Eastern Paralyzed Veterans Association of Jackson Heights, but I live in New City, which is in the Hudson Valley. And I have been a patient at Castle Point as well as at the Bronx and a number of other VA institutions.

Thank you, Mr. Chairman. We have presented testimony for the record in writing, and I will not try to repeat all of that now and just make a few points that I think are important for you to hear.

Castle Point has been a very important part of the hospital system for our members. It has been 1 of the SEI care centers in the Nation, 1 of the 22 SEI care centers.

Right now as part of the restructuring of VISN 3, the three centers have been combined under one, which will be headquartered at the Bronx. There will be beds at Castle Point. But what has happened is that we have had to move our plastic surgery program, which we helped to underwrite, from Castle Point to the Bronx. It's no longer available in the Hudson Valley for Hudson Valley veterans.

We have seen the number of our members who go to Castle Point and also the number of our members who now go to the SEI center reduced because of this increased need to travel further for the specialized care.

The VA SEI care system is the only care system of its kind in the Nation. It's one of the specialized care programs. It has been recognized as such and has been picked out or singled out for special funding.

One of the things the SEI care system does that is not done in the private sector is sustaining care that they provide for our SEI veterans, our spinal cord-injured and disabled veterans.

We have been concerned about the availability of that care. And while we recognize that the access points are a big plus for veterans in general, for veterans with spinal cord injury, they have not been as available because of some problems, first of all, with the specialized care availability and in other cases wheelchair accessibility to some of those centers. That's also been a problem.

The other main thing we have been concerned with is the quality control issues. We have discussed today with some of the witnesses that there are new systems being put in place to assure quality control is maintained on a nationwide basis in a more uniform basis. We talked about some of the sentinel events which will trigger investigations. We're very happy to hear that because we have been tracking what's happened about the country.

One of the biggest problems has been mistakes which have been made many times because of the fact that there has not been a reporting system and investigations have not been done properly to followup on these.

I'm concerned that what is identified as a sentinel event is properly done because I know there's been some things which are the explanation of what a sentinel event is, which would not have been identified as such. And those problems would have, again, been

continued. So we're going to be watching that very carefully. And I know the committee will also.

We know the VA needs to be reformed. We just hope that the Veterans Affairs Committee, the Government Reform and Oversight Committee, and the other Members of Congress who are responsible for overseeing what is done to our Nation's veterans make sure that those changes take place in a proper manner. We need to save money, but let's do it while we're also protecting veterans.

Thank you.

Mr. SHAYS. Thank you, Mr. Kelly. [Applause.]

Daniel Reilly from Beacon?

STATEMENT OF DANIEL REILLY, VETERAN AND NFF 246, BEACON, NY

Mr. REILLY. Good afternoon, Members of Congress, ladies and gentlemen. My name is Daniel J. Reilly.

On December 1, 1976, after having served in the Air Force, I began my career with the Veterans Administration Service. I worked at the VA hospital in Montrose until August 1990, when I transferred to the medical center at Castle Point.

I feel that in the spirit of the difficulty both Castle Point and Montrose are experiencing at this time, the two facilities remain a good place in which to work. These facilities afford veterans the necessary care and treatment they surely deserve.

As a spokesman for NFF, which is the local out there, 346, I should express feelings of the members that our drastic downsizing and cutbacks are what contributed to the poor morale and bad publicity by the newspapers, what we have experienced.

We already had experienced cutbacks and downsizing with the public sector in this area and now with the same happening with the government, families especially. We veterans feel hurt, helpless, what in the future will help us all.

It is apparent that the government is willing to sacrifice funds for veterans' programs and health care by appropriating these funds for other resources that are deemed more important than for the veterans who served their country so faithfully.

I, as a veteran, am especially saddened when I think of where the future lies for the young men and women who are now serving and will serve their country in the future.

In conclusion, I am among the many others here today who respectfully ask for all of you to support us in our time of need by doing all that you can to help see that the rights of veterans are upheld to the highest standards possible by keeping our veterans' programs in health care alive and well for all veterans today and tomorrow.

Thank you. [Applause.]

Mr. SHAYS. Thank you, sir.

Our next few witnesses: Kenneth LaFontaine did not give a city or a town, Harry Fleming from Middletown, and Shirley Mangels from Ellenville. Is Mr. LaFontaine here? Then our next speaker will be Harry Fleming. Mr. Fleming from Middletown.

Mr. FLEMING. Thank you very much.

STATEMENT OF HARRY FLEMING, VETERAN AND CHAPLAIN AND SCOUTING CHAIRMAN, ORANGE COUNTY AMERICAN LEGION, MIDDLETOWN, NY

Mr. FLEMING. I am with the American Legion, the past commander of Post 151 here in Middletown. And also presently I'm the Orange County American Legion chaplain and the scouting chairman for the Orange County American Legion.

As a whole, with Castle Point, I have not too many problems. I did, and which I have brought to Mr. Gilman's attention. I've had a problem with one doctor over there. And he was a doctor that you could not talk to as I undergo daily pain from osteoporosis, arthritis, and diabetic neuropathy. And I have pain 24 hours a day, 7 days a week. The doctor argues with me, tells me it's in my head. And I tried talking with the doctor to no avail.

I ended up changing doctors over there after he pulled a sneak one on me. He canceled an appointment on me for the hospital down in Manhattan. And, subsequently, I had to end up going to a local hospital and being transferred to Columbia Presbyterian, which would end up costing me $7,000 out of my own pocket because he canceled the appointment and didn't even tell me.

That's all I have to say.

Mr. SHAYS. Thank you, sir. [Applause.]

Our next speaker is Harry Fleming from Middletown. Oh, I'm sorry, Harry. You just went now. I'm sorry, Harry.

Shirley Mangels, is she here? Thank you. Way in the back there.

STATEMENT OF SHIRLEY MANGELS, DAUGHTER OF DECEASED VETERAN, ELLENVILLE, NY

Ms. MANGELS. I'd like to thank you for letting me speak here today.

My father had been a patient at Castle Point, an outpatient at Castle Point, for 3 years. So what I'm about to tell you cannot be said happened because there was no knowledge as to what his medical status was.

On January 20, my mother took my father, Clifford Madison, to the Castle Point emergency room. He had been coughing, complaining of shortness of breath, and had a frying sound when he breathed, audible without a stethoscope. His ankles also displayed some swelling.

The emergency room doctor, whom we discovered later on was only moonlighting at Castle Point, was not a regular staff doctor, told my mother that there was essentially nothing wrong with my father, that he had maybe an occasional drip in his lungs, which was not considered unusual for an older person, but there was really nothing wrong. And on the records, what he listed my father's condition as was "viral syndrome."

Well, guess what? In about 36 hours or so, my father became progressively worse to the point where he was incoherent. And on Monday morning, January 22, he had become critically ill and had to be transported to Ellenville Community Hospital, where there they found that both lung fields——

Mr. SHAYS. Excuse me. Would you just suspend a second? Could we shut the door? I'm having a difficult time hearing. I'm sorry. I really appreciate all your patience. We don't have the most com-

fortable chairs to sit in, and some have not been able to sit very long. Thank you.

I'm sorry to interrupt you, Ms. Mangels.

Ms. MANGELS. Quite all right.

X rays revealed that fluid was in the lower two-thirds of both lung fields and that this area was filled. There were fine and coarse rails anteriorally and posteriorally in both lung fields. There was also cardiomyoglian evidence of swelling three to four plus.

Later that day, my father was transferred to the VA facility at Castle Point in extremely serious condition because Ellenville did not have a blood gas machine that was working properly at the time.

From there on, my father at one point began to progress and began to show signs of becoming well. And, as a matter of fact, the one doctor that was observing him at the time told me that my father would be home in about 3 days.

Well, later on, my father on February 10 passed away. The same doctor that less than 2 weeks prior told my mother to take him home, same emergency room doctor, comes into my father's room and pronounces him dead.

Now, we have been to an attorney about this. And we have gotten an independent physician's results on what he gathered from reading my father's records. This is the statement that he gives,

I have read the medical records recently forwarded to me, having particularly to do with the above-captioned person's visit to the Castle Point VA emergency room on January 20, 1996, the subsequent events at the Ellenville Community Hospital on January 22, 1996, and subsequently again at Castle Point VA Hospital extending until the time of his demise.

On the basis of these data, it is my opinion that the emergency room record from Castle Point VA Hospital generated by a physician on call in the emergency room whose name is illegible to me represents a disgrace to the medical profession and certainly to the Veterans Administration.

Among other things, this record under the "Triage" section does not truly, fully, and accurately relate the patient's problem and complaints. Complaints at this time were particularly: shortness of breath, wheezing, and swelling of the feet and ankles. These problems were not indicated on this medical record.

The section for history and physical is unbelievably below standard in essentially all respects. The entry shows the presence of occasional bronchi in rails and no wheezes, which is contrary to the history. There was no comment regarding the question of veins in his neck, his color, his general condition, the presence or absence of pulmonary findings on percussion, such as dullness and/or a decreased——

Mr. SHAYS. Ms. Mangels, could I just—given the severity of your concern, for obvious reasons, I want to give you some leeway, but I do need to have a sense of how much longer you'll be because——

Ms. MANGELS. Not very much longer.

Mr. SHAYS. OK. You'll finish up in a minute?

Ms. MANGELS. Yes.

Mr. SHAYS. Thank you.

Ms. MANGELS [continuing statement].

Under abdomen, there appears to be simple negative regarding ornagamy and other problems and under extremities, no entry of pedal edema, which is contrary to the obvious fact.

This history is such as to contribute to the formulation of anything like a reasonable, accurate diagnosis. And indeed in this case, no such diagnosis was made. The physician entered as diagnosis "viral syndrome" with nothing whatsoever to support this. And he also noted "increase" in the person's "pt time," which in my opinion had nothing to do with the presenting problems.

On the basis of these information errors, the doctor advised the patient's heart and lungs were OK; there was an abnormality in his pt time, which should be corrected; and he was summarily discharged to go home.

I'll just skip down through here. The doctor continues,

It is my opinion that the 2-day hiatus with no treatment materially adversely affected his cardiopulmonary situation to the extent that myocardial infarction was precipitated by his hypotension, hypoxia dyspepsia, . . . Pneumonia was likewise a direct and result of the untreated pulmonary problem over these 2 days. Therefore, this hiatus of no treatment in my opinion was the proximate cause of his demise.

I would like to say one thing. All of this took place before the talks of cuts and everything else. There was a problem before. The problem is just not money. That's the tip of the iceberg.

Your problem is having competent health care-givers at these facilities. You want to expand facilities? You want to put some facilities in Monticello and in different areas? You'd better make sure that you've got people competent enough to run these facilities because if you don't, you're going to have more deaths on your hands, more mutilations, and so forth.

Mr. SHAYS. Thank you. [Applause.]

Our next three speakers are: Joseph Montemarant from Hopewell, Henry Lendzian of Warwick, and Pam Jinks from Montgomery. Is Joseph Montemarant here? Is Henry Lendzian here? Is Pam Jinks here? Ms. Jinks?

Let me just say to you that we're going to just go down the list, and we'll stay here until 6 o'clock. Sir, we have to have some way to do it. So we'll just go on to the next person who was randomly picked.

Let me just say something here. We do have one obligation, and that is that this room is going to be used for another group afterwards. So we're going to try to finish up in another hour and a half. We're going to go another hour and a half. That's 6 o'clock.

Are you ready now, Pam Jinks? Can we start? Thank you.

STATEMENT OF PAM JINKS, VETERAN AND CASTLE POINT EMPLOYEE, MONTGOMERY, NY

Ms. JINKS. My appeal is to the representatives who appear to be jumping on the bandwagon to use Castle Point and Montrose VAs as their political crusade.

I am a veteran as well as an employee of Castle Point. I'm concerned that all the adverse publicity that we have been receiving is going to be the downfall of two facilities that have faithfully served our veteran population for more than 50 years.

In this time of health care reform, it's imperative that the VA keep abreast with the private health care industry. The VA can no longer continue to operate as we have in the past. And the taxpayers can no longer be expected to foot the bill of this enormous program without the government taking drastic measures to cut costs and work more efficiently.

By doing so, we are effectively downsizing, a word well-known in the corporate world. Along with that comes anger and fear from the affected employees as well as the population we serve.

Congress approved VERA without knowing the full ramification of this bill. You listened to the bean counters, who projected shift

in the population. You felt this was good for the Nation, but you were forgetting the ones that were left behind.

I understand that the veterans who use both the New York facilities and Florida have said that the Florida facilities are beautiful, but books can't be judged by their covers.

The New York hospitals are under attack because you're asking every disgruntled patient and family to come forward. Could any hospital survive this type of attention? I doubt it.

The industry is still based on human judgment, which includes errors. We have not entered the era yet where IBM has developed a program designed to perfection for the medical profession, as they did for chess. We still use the human physician judgments. Why you ever opened up the floodgate is beyond me. Along with their failures, there have been successes. But you never ask for them.

I happen to be proud of Castle Point. I began working in Outpatient, then spent 10 years in Quality Assurance. So I know the weaknesses as well as the strengths of this facility.

For the past 18 months, I have served as supervisor of primary care. I'm a member of the Women's Veteran Committee as well as the POW Committee. By being a member of these committees, I know that the facility has identified areas for improvement and is continually working to resolve the issues that are brought forward.

Positive changes and implementation have begun. We continue to work with the service organizations to see that corrective action is taken. If anything, because the administration has changed, we are now able to quickly make corrections and address issues without the barriers placed on us in the past. Though change is always resisted, I believe that the merger of the two hospitals will benefit the community in the long run.

Thank you.

Mr. SHAYS. Thank you very much. [Applause.]

Thank you for your testimony. Our next three witnesses will be: Enrico Messina from Poughduag, if I'm saying that correctly, Sandra Schwartz from Poughkeepsie; and Anne Bove from Woodside. Is Enrico here? Thank you, sir.

STATEMENT OF ENRICO MESSINA, VETERAN AND CASTLE POINT EMPLOYEE, POUGHDUAG, NY

Mr. MESSINA. Good afternoon, ladies and gentlemen at this congressional hearing. I come before you today to speak openly and honestly about Castle Point VA Medical Center. I will share my experiences and blessings.

I am a veteran of the United States Army who served as a medical corpsman in the United States and was in Vietnam for 11 months and 26 days. I truly believe that God sent me to Castle Point to provide nursing care for our honorable veterans who stay or use the medical center and outpatient clinics.

I started my career at Castle Point in the nursing home on the B–1 unit, where I met, talked to, and provided the best possible care with the staff assigned to that unit. I am proud to look at each one of you here today and say that each day the men, in some cases women, patients were treated with dignity, compassionate hands, and skilled nursing care.

These veterans were called to duty, as I was, in their late teens and early 20's to serve our country in a foreign war and engage in battle knowingly for the love of their country without asking themselves, "Why me?" or "Why us?" They just did the job and served honorably for their country.

Many of these veterans' minds and bodies were scared for life, requiring compassion and love. Each day every patient was provided the activities of daily living.

Some patients lost their limbs, legs, and arms during the battles they fought. Therefore, washing and showering and dressing them in neat, presentable clothing was provided them each day. Their teeth were brushed. Dentures were cleaned. And their hair was combed. A dialog with these patients took place either in their daily care or while feeding them at their bedside.

Many of our freedoms that we have today we sometimes take for granted. These veterans, though, through their courageous efforts gave us this freedom that we have today.

I, for one, am very grateful for the freedom of speach. I as I stand before you today ask you that you please do not take these and other freedoms of our veterans away.

I challenge you all today to let us continue to provide the best medical care to our loyal veterans in an expedient way, which should be the way to always be maintained at a level second to none. You now have an opportunity to fight for us at each of your congressional and State levels of government, representing the people; in particular, all veterans.

The nursing home also provided a religious atmosphere for each veteran and their families each day from our priests, reverends, and rabbis. Weekly services are offered to all. Many look forward to going before their God and praying in their own individual ways. How blessed they are to have this religious dedication at our facility.

I have seen and heard the power of prayers at a time of need when many of our veterans are called home by their God. And the support was very uplifting for their families and the staff alike.

The recreation representatives along with many volunteers provided such things as music therapy, pet therapy, bingos, movies, trips to local ball games, and fishing spots, which provides ongoing mental and physical stimulation that is needed to progress and have happiness in this world. These people sometimes go unnoticed, but I, for one, want to say thanks for the many smiles and words of appreciation that veterans shared with me after enjoying these recreational experiences.

Yes, sir?

Mr. SHAYS. Mr. Messina, you got here at 9 a.m., and helped set up this room.

Mr. MESSINA. Yes, sir.

Mr. SHAYS. So my heart wants to let you speak a little longer, but we do have other speakers. So could you kind of wrap it up?

Mr. MESSINA. I have about 3 minutes, sir. Would you give me the opportunity?

Mr. SHAYS. You have used 3 minutes. You may have more than 3 minutes. I just would like you to bring it to a close.

Mr. MESSINA. I will try to read fast, sir.

Mr. SHAYS. Maybe cut out a little bit if you have to.

Mr. MESSINA. OK. Many of our World War II veterans require and will continue to require these and other surgical procedures. I address the OR. We'll skip over that, sir.

I will give you a copy of my report, sir.

Mr. SHAYS. It will be in the record.

Mr. MESSINA. Please be mindful that the travel for these procedures to other VA facilities outside the normal traveling radius and in unfamiliar areas is a true hardship for my fellow veterans and their families, who are in the 70's and 80's. They need and want to continue to utilize the Castle Point facility.

What we all did without second thoughts in our healthy 20's, 30's, and 40's becomes a frightening experience for us all as we will increase in age and find it hard to travel. These veterans will find it impossible to travel outside their living areas for the medical support they deserve and were promised.

This past January, I was given the opportunity to serve our veterans in the outpatient clinic area. Hundreds of our patients visit the clinic each week to see the physicians, nurse practitioners, and nurses for their medical needs and medications.

Preventative education to the veterans is vital to the continuing health for the future. We all at Castle Point strive to make this a positive visit with quality care, love and dedication to our veterans being the utmost importance.

One of our ongoing goals is to continue to track new veterans by offering the best quality care that they need and deserve. We are a proud team willing to increase our offerings and expand our programs for these men and women veterans at our clinics.

I would not be here today if it were not for the many articles published in the area newspapers that were very disruptive to our veterans at Castle Point. This is where I work each and every day to provide skilled nursing with love and compassion. In response to these articles, I have never seen, nor would I ever stand for, any veteran who required care and did not receive that care in a timely and professional manner.

I beg each of you here today to continue support of the veteran population, these veterans here today and to those who could not make it here.

Mr. SHAYS. Mr. Messina, I do need to ask you to conclude.

Mr. MESSINA. In closing, I remind you of your challenges ahead to not only seek the truth, but be open and honest to us as veterans. As you allocate the dollars to all Veterans Administration health care facilities, you, as our elected officials, have the power to vote into and present new laws that will affect us as veterans.

Our veterans fought and served for us. Now the opportunity is yours. Fight for us so we can continue to provide the ongoing excellent health care at Castle Point.

Respectfully submitted, Enrico Messina.

Mr. SHAYS. Thank you. [Applause.]

Mr. Messina, thank you again for getting here at 9 a.m., to make sure that we had our chairs set up and this room set up. It was very nice of you to do that.

Our next speaker is Sandra Schwartz from Poughkeepsie. Where are you? I'm sorry. OK. Thank you. You're on.

STATEMENT OF SANDRA SCHWARTZ, VETERAN, WIFE OF VETERAN AND DAUGHTER OF DECEASED VETERAN AND DISABLED AMERICAN VETERANS AUXILIARY, POUGHKEEPSIE, NY

Ms. SCHWARTZ. I am with Disabled American Veterans Auxiliary. I am a volunteer member of the Disabled Committee of the Dutchess County Human Rights Commission. I sit on the Roundtable for Racial Harmony. I have served on the board of Taconic Resources for Independence, which works closely with the Eastern Paralyzed Veterans. I am the daughter of a soldier who paid the ultimate price, and I am the wife of a veteran.

The VISN statement is proudly and prominently displayed on the corridor wall at Castle Point. It states, "Serving those who served our country with quality health care second to none." Likewise, the mission statement, also proudly displayed, echoes this intent commitment.

Whereas, Webster's Dictionary defines the word "quality" as meaning "a grade of excellence," the veteran is aware that the words "quality health care" are being bandied about and are constantly redefined in the direction of diminished care and perhaps "equal to none."

There are definite indications that the hospital as we knew it really doesn't exist any more but has become a shell of itself. It has been downsized, peeling away on a step basis the confidence of the veteran and veteran's family and raises questions as to what criteria can still apply to it as a standard if it is no longer a hospital.

Webster also defines a hospital as being "an institution where the sick and injured receive medical, surgical, and emergency care"; whereas, a clinic is defined as "a facility associated with a hospital that treats chiefly outpatients." This likens Castle Point's transformation into a satellite, a field first-aid station, as in places of combat, where primarily the only aid rendered was preparation referral and transfer to a base hospital.

Contracts with Vassar, St. Francis, or other community hospitals are being considered to provide emergency room services. In the absence of these services for inpatient or outpatient, how can anyone conceive of Castle Point being considered as a medical center?

After gutting these medical, surgical services, what remains is little more than a primary care referral, recordkeeping, and pharmacy service under the heading of a medical center. These actions combined with reduced funding and lessened services construct a climate which will further discourage veterans from seeking care at Castle Point. Perhaps this is the ultimate objective: the reorganization to compromise the veteran in the interest of budget balancing.

Placing the burden of further travel for medical care for the sick and spinal cord-injured veteran, including the elderly ones, is most inconsiderate and tantamount to cruelty to them and their families.

A spinal cord-injured veteran who had been sent to the Bronx Medical Center reported back that the ratio of patients to personnel for his ward was 7 to 1. It certainly was not an ideal circumstance. A lot of patients in this type of ward need a lot of help. And short-staffing endangers their lives.

The Federal Government has promised its citizens to be the role model for persons with disability as provided for in the Rehabilita-

tion Act of 1973, as amended, and the Americans With Disabilities Act. Yet, we see in this reorganization a disregard to these special citizens through dilution of their deserved quality care by proposing contracting with non-veteran, profit-based, community entities, reducing access and availability of VA expert competency centers.

This past Thursday as I was preparing remarks for this hearing, I observed a fire drill on the hottest day of the year, which caused a veteran in his wheelchair to be moved outdoors. It turned out that he was abandoned there, which resulted in his succumbing to the heat. And he slumped over with his head leaning against the hot bricks. As a bystander, I personally notified staff of his need for immediate aid.

Another issue at this time when the fire drill was repeated, I noticed a very long line of 20 to 30 patients awaiting their turn at the scheduling desk on the third floor disregarding the alarm because they were concerned about losing their place in line and finally being herded by staff into an already-occupied small room to at least get them to move out of the corridor. Even the elevator continued to operate for a fire drill. It appeared that the actions taken were ill-conceived. And it caused me to wonder, "What if it were not just a drill?"

On Friday, August 1, 1997, 2 days ago, I was at Castle Point and received a firsthand account of the eroding of quality care. A veteran who had previously undergone a bad surgical experience at Castle Point was scheduled for a different procedure. He had expressed his concerns to the doctor, who reassured him in order to allay his anxiety that the instrumentation, a flexible soft scope, would be used for cavity insertion to prevent injury during the examination.

The veteran arrived at the appointed hour fasting and was kept waiting for 2½ hours before he was summoned to garb himself in surgical attire. And he was placed on a gurney in the operating room, prepped for the procedure, which was then commenced. The procedure had to be abruptly halted——

Mr. SHAYS. Ms. Schwartz, you've been about 5 minutes now.

Ms. SCHWARTZ. I have one page, and I think it's important.

Mr. SHAYS. Everybody thinks their statement is important. Please finish up.

Ms. SCHWARTZ. Yes, sir. But if it's not read and it's not recognized——

Mr. SHAYS. Ma'am.

Ms. SCHWARTZ [continuing]. He yields his time to me, there could be a lawsuit, which could be avoided.

Mr. SHAYS. Let me be very clear here. At 6 o'clock, we're going to end. There will be some people who will not be able to testify because some people, quote, spoke 5 and 6 minutes. I'm very willing to let her proceed, but I'm just making the point to you that other people won't be able to speak at all. If you think that's fair, we may proceed.

Ms. SCHWARTZ. When the doctor called for the flexi-scope and was only then informed that the supply for Montrose and Castle Point had been used up prior to the veteran's scheduled procedure and that only a rigid, thicker fiber scope was available, the expla-

nation offered was that all three of the necessary devices had been used up prior to his scheduled appointment and the sterilization process before reuse had not yet been accomplished.

So the patient was told to redress and reschedule for a repeat procedure. The doctor apologized, saying she was impacted by overbooking and that they had just handed her a clinic, which she was late for.

Poor pre-planning and the lack of ample equipment, resources, and staff could hardly exemplify quality health care. Is this the benefit of the Castle Point-Montrose merger? Savings should not be accomplished at the veterans' risk.

Also noteworthy is the recent rash of musical chairs being played at Castle Point, where medical care personnel unfamiliar with patient history substitute for specialists without background in that specialty. Additionally, there has been substitution by practical nurses for consultation in the place of specialists, no doubt due to short staffing.

Fairness to the veteran population dictates that they be held different in budgetary matters. Opportunities which you people enjoy today are because of what they sacrificed yesterday. Stop imposing on families for third party contributions. Stop robbing their families. Stop robbing the veterans. Stop those who have conflicts of interest and bonuses.

Veterans are special citizens who have paid their dues and contributing fees in advance with heavy consequences to them and their families. The cost of war does not end at the treaty signing. But fairness to the veteran is recognizing that the debt is ongoing.

Let's not nickel and dime them to death by being deadbeats to our veterans. Restore funding to our Northeastern veterans. Restore funding and refresh Castle Point to the quality care hospital it used to be.

Thank you.

Mr. SHAYS. Thank you, Ms. Schwartz. [Applause.]

Our next speakers are: Anne Bove from Woodside. Is she here? Anne? And let me just say who will be following: Robert Jirak from New Paltz. Is Robert here? Robert is not here, I gather. Karl Rohde from Carmel. Is Karl here? He had to leave. And after Karl is Patricia Hulse from Sparrowbush. Is she here? OK.

Well, I'm sorry to keep you waiting. Anne.

STATEMENT OF ANNE BOVE, REGISTERED NURSE AND DAUGHTER OF DECEASED VETERAN, WOODSIDE, NY

Ms. BOVE. My name is Anne Bove. And I'm speaking on behalf of my mother and one of her neighbors with regards to their husbands, respectively.

My father, Frank Bove, as well as Mr. Carmine Gracioso, were both World War II veterans. My father was in the Service for 10 years. Both of the men saw combat duty during the Second World War. My father was 35 percent disabled. Both men recently have passed away.

My father, as well as Mr. Gracioso, suffered from complications of what I call inadequate staffing. I'm a registered nurse that works in a municipal hospital in New York City, so I can understand about governmental restrictions in terms of financial compo-

nents. But I think the financial components that have restricted the particularly nursing care with regard to what these patients well-deserve has gone far and above what I consider or any of these patients deserve.

My father basically got wonderful care at Castle Point up and until February 1997, when restructuring happened. At that point, he was in a nursing home section and was put into another nursing home unit that had much more acutely ill patients with less nursing staff.

Subsequently he broke his hip, was operated on at Manhattan VA, which he got excellent care at, came back to Castle Point and the cascade of events that happened to him, once again indicators of poor nursing care, resulting basically from the lack of staff.

I think it's important to look at morbidity and mortality, but there are other indicators that will show whether or not the provision of care has been adequate, such as: the number of falls a certain facility might have, the number of pressure ulcers a patient will develop. I think all of those things need to be considered.

And in the case of my father and in the case of Mr. Gracioso, those complications did ensue and much shorten their not-too-long life expectancy, but a little bit more time that we could have spent with them in terms of quality.

I hope that consideration is made to enhance the VA system as not to do away with it because it's a much needed system for a very special patient population, of which my father was once a member.

And that's really all I have to say right now. Thank you. [Applause.]

Mr. SHAYS. Thank you, Ms. Bove. Just again I'll call Robert Jirak is not here. Karl Rohde? Patricia Hulse? None are here. John Earley? Is John here from Pine Bush? John Ippolito, is he here? John, you have the mic, sir.

STATEMENT OF JOHN IPPOLITO, VETERAN AND AMERICAN LEGION POST 1266, PINE BUSH, NY

Mr. IPPOLITO. My name is John Ippolito. I'll make this short and sweet.

What I have heard here today is that the VA hospital should be doing more with less. So bonuses can be paid to perpetuate human misery by staffing cuts in our patient services to veterans who really need hospital care. This sucks. And I hope our congressional Representatives who are here today do something about it and soon.

Thank you. [Applause.]

Mr. SHAYS. Thank you, sir.

Nicholas Bucci, is he here from Marlboro? Ralph Demarco from Fishkill? Ralph, you've got the floor. What I'm going to do is I'm going to tell you when 3 minutes come. The will of the group—I'm just going to say the will of the group is to let you go. And if you take someone else's time, you do. But I'll let you know when your 3 minutes come.

Mr. DEMARCO. You have my statement. I'll skip over what I think is important.

Mr. SHAYS. OK.

STATEMENT OF RALPH DEMARCO, VETERAN AND REPRESENTING 27 NEW YORK VETERANS' ORGANIZATIONS, FISHKILL, NY

Mr. DEMARCO. First of all, identify myself. I'm a member of the Board of Directors of the Veterans of Foreign Wars of the United States. I'm the New York State VFW legislative chairman. I'm president of the New York State Council of Veterans' Organizations, legislative representative. Most important, I'm a member of the New York/New Jersey Management Assistance Council for Network No. 3 and Network No. 2. I'm also a member of the Care Line Implementation Team for Network No. 2 for the Department of Veterans Affairs. To let you know, I represent 27 veterans' organizations, major organizations in the State of New York. I'll get to the part where I think is important.

As a member of the New York/New Jersey Veterans' Integrator Service for Networks 2 and 3 Management Assistance Council and also a veteran for the Network No. 2, its Product Line Implementation Team, we have been the veteran's advocate at all network meetings. The network directors at the MAC meetings provided us with sufficient opportunity to state our position on and issues, discuss our concerns, and have been responsive to our concerns and questions.

Due to the bad press recently at Castle Point-Montrose, VA received many calls from the media, where I appeared on television in an hour program answering questions from the veterans across our State, also been interviewed by major newspapers and three radio stations across the State.

With the members of the council, we have toured Montrose and Castle Point Medical Centers and found them to be clean and orderly. The employees went out of their way to accommodate our wishes. We talked to medical and nursing patients and also were satisfied with their treatment and services, met with Dr. Kizer at Castle Point, where he explained the deaths.

As far as VERA is concerned, we have long supported the concept of equal access to VA health care for all veterans, but we are concerned, however, that those networks which will receive fewer funds will begin to limit access and service. We will watch closely and will examine every complaint and every individual base.

Here's something that our good Congresswoman is interested in: treatment of medically-indigent veterans. These veterans are in grave jeopardy of becoming victims of an inadequate VA budget. Even though VA mandates to provide all needed hospital care to low-income veterans, they will only provide care to the extent that resources and facilities are available. Thus, if Congress does not appropriate adequate funding, this class of veteran may be denied care.

We have been and continue to be committed to being champion of the medically-indigent. We will fight to see that their health care needs are fully provided by the VA.

Another thing that we find very disturbing is the VA nursing home closes. Nursing home eligibility has not changed with the Eligibility Reform Act of 1996. It is still discriminatory and may provide when medically indicated and to the extent——

Mr. SHAYS. You may keep reading, sir. I was just going to let you know your 3 minutes are up, but keep reading.

Mr. DEMARCO. All right. Just to close, with the coalition of major veterans' groups, we recommend that if enacted, it would strengthen programs and services provided to the Department of Veterans Affairs.

These recommendations are contained in the 11th Annual Independent Budget for Veterans' Programs developed by the Veterans of Foreign Wars, the AMVETS, the Disabled American Veterans, and Paralyzed Veterans of America.

The report recommends—this is where we think it's important—$43.2 billion in appropriations for the fiscal year 1998, a 7 percent increase over the current appropriations, including $19.7 billion for compensations, pensions, and burial benefits. And the recommended appropriation for veterans' medical care is $19.5 billion.

The VA's attempt to be cost-effective may in some cases be taking precedence over efforts to provide high-quality care to veterans. The recommended funding levels in the independent budget will enable the VA to continue serving our veterans.

Thank you for your time.

Mr. SHAYS. Thank you, Mr. Demarco. [Applause.]

Our next speaker is Philip Oppenheimer from Greenwood Lake. Is he here? Our next speaker after that is Andy Layer from Beacon. Is Andy here? Our next speaker is Warren Craig from Newburgh. Is he here? James Applegate from Goshen? Jim is not here? Robert Kavana—am I saying that name correctly—from Crugers?

Audience PARTICIPANT. Kavana.

Mr. SHAYS. Kavana? K-A-V-A-N-A?

Audience PARTICIPANT. He's gone. He's gone.

Mr. SHAYS. OK. Steven Fleck from Poughkeepsie? Is Steven here? Yes, Steven. You have the floor, sir. I'll tell you when your 3 minutes are up.

STATEMENT OF STEVEN FLECK, VETERAN AND MONTROSE EMPLOYEE, POUGHKEEPSIE, NY

Mr. FLECK. All I've got is one short statement. I work at Montrose. I've been there 13 years, and I'm very proud at working at both facilities. I've dealt with the Bronx. I've dealt with Manhattan. I've dealt with all the things. I'm a driver. I drive these veterans around wherever they want to go. And I go out of my way for them. And I appreciate the hospital. I'd rather go to a VA hospital than a private hospital.

Thank you.

Mr. SHAYS. Thank you, sir. [Applause.]

William Munday from Wurtsboro. Am I saying that name correctly? And Richard Thornton from Poughkeepsie. Is he here? OK. Let me ask you this. I have a list that I could go through. How many people would still like to speak? Would you raise your hands? OK. What we're going to do, those of you who can stand up, would you just stand up so we can just identify you again? I understand. Those who could, sir.

OK. What we'll do is we'll be able to finish. And that's very nice of you. Sir, we'll start with you. And then we'll just go right down

the line. Everybody gets to speak. You're first. Why don't you get a mic here?

Now, let me just tell you the challenge we have. When we're done, we need you to write your name and your address and everything because we need to make sure we give it to the transcriber.

But we need the mic so people back there hear you as well, and we need it for transcribing. Excuse me, sir. We need it for the transcriber as well. So you're going to have to take the mic.

STATEMENT OF THEODORE DOBBS, VETERAN AND HUSBAND OF DECEASED VETERAN, NEW HAMPTON, NY

Mr. DOBBS. Certainly. My name is Theodore Dobbs. I'm a World War II veteran of the Navy, as was my wife, Marian Dobbs. She died in the Bronx VA Hospital. Those are all her charts. I need copies of those charts back again. They're facts of what happened.

She was admitted with an infection. And when she was told by the doctor admitting her in Montrose, he said, "Is it OK if we keep you here for a while?"

And she said, "It is if you can cure my infection."

So he says, "Well, I think we can take a crack at it."

So there was somebody there. And I'm not going to mention her name, and I hope I don't seem like too much of a ham when I speak about it.

She said, "I remember the night that your wife and your daughter and you came in here."

She said, "It was a rainy night, and it was December 18, 1996."

And she said, "And then it lasted past midnight. And when the doctor said to her, 'I think we can take a crack at it' so that she would stay there, he was lying through his teeth because we have no antibiotics here at all. He just said that to placate her and to make her obey him to stay there." And so, as a result of the negligence of that problem, she died.

I want you to know I want the veterans' hospitals to be just as perfect as they can be, but I think that there's an insurance problem here. Insurance is behind everything that the government funds, and that's got to stop.

That's all I've got to say. I loved my wife, and I was married to her for 9 days short of 52 years. I wish I had never sent her to a VA hospital, but now we're going to change those things for the better. We're going to make them what they should be. Am I right? [Applause.]

Mr. SHAYS. Sir, I'm going to ask everyone speaking now to fill out a pad afterward just to make sure we have your address. And we'll be taking it over. We'll bring it to you. And your name again and your town, sir?

STATEMENT OF CRAIG SHERA, VETERAN AND SON OF DECEASED VETERAN, GARDINER, NY

Mr. SHERA. My name is Craig William Shera. I was in the Navy, and I also was in the Army, got out of both of them. My father died in 1987 at Castle Point VA Hospital.

Mr. SHAYS. What's your community, sir?

Mr. SHERA. Gardiner, NY.

Mr. SHAYS. Thank you.

Mr. SHERA. My father died in 1987. He was diabetic. He had total kidney failure. Renal shutdown they called it. And he lasted 7 days in that hospital. He had five heart attacks. And they tried to save my father's life.

I think the people at Castle Point are getting a bum rap, and it's all political. We know it. I know it. I'm not as well-educated as you guys are, but this is how I feel.

The woman on the end, I don't really know her name because I'm not a Republican. [Laughter.]

I heard she voted to send the money down south to this bill. And if that's the case, if she doesn't know what she's voting for——

Mr. SHAYS. Sir, let me just be clear on this. You're talking about the Veterans Equitable Resource Allocation.

Mr. SHERA. Yes, I am. All the terms, I lived in the military for 14 years——

Mr. SHAYS. We call it VERA.

Mr. SHERA. Yes.

Mr. SHAYS. That's a decision that we mandate to the Veterans Department to do certain efficiencies and so on. They then decide how they are going to incorporate the——

Mr. SHERA. What I want to know is——

Mr. SHAYS. Let me just finish making this point.

Mr. SHERA. I know. I know.

Mr. SHAYS. And the point is then Congress looks back and says, "We're not comfortable with the direction you're going, and we need you to look at doing it a different way."

It would be wrong for any Member of Congress to say that we don't want the veterans' facilities to become more efficient. How they become efficient becomes an administrative responsibility. And then Congress looks at it and says, "We like the direction you're going" and not.

Mr. SHERA. Yes.

Mr. SHAYS. It clearly has to be a team effort.

Mr. SHERA. I understand that.

Mr. SHAYS. OK.

Mr. SHERA. But what I'm trying to say is that if they can send money to send that space shuttle up every fricking week like they've been doing—[applause]—why can't they send the money to where we need it for Americans? We went to the Persian Gulf to help the Arabs. We went to all of these other countries to help them. Why don't we just help our own veterans?

My father died at Castle Point. They didn't kill him. He died. But they treated him well. And it gets me mad. They treat me well there. And when they start closing that down, I don't have nowhere to go. I have no insurance.

Thank you.

Mr. SHAYS. Thank you very much. [Applause.]

Would you bring the mic, please, to our next speaker? Our next speaker is right there. Sir, you're a State Commander? I'm sorry. The gentleman who just spoke.

STATEMENT OF GERARD MILEO, VETERAN, MARLBORO, NY

Mr. MILEO. My name is Gerard Mileo, Marlboro, NY, United States Marine Corps, Korean war.

Someone is to blame. I'm listening to all of these people out here. Thank God I haven't had time to use the VA hospitals. Maybe I have a second thought now.

I listen to these people. And they're making a point. Who is to blame? You can't solve a problem unless you find out who caused the problem or what caused the problem.

My opinion is our elected officials haven't been doing their job. Don't take this personally. This goes back to 1945. You people got in office recently or a few years ago. But they have let us down. Corporate America has let the working man down. And our Government, whom you people represent, has let the veterans down.

Congressman Hinchey, don't take it personal. Would you send a member of your family to a doctor that's not registered? You are aware of it. From what I'm hearing, that doctor is still doing business in a veterans' hospital. That's wrong. [Applause.]

If Bethesda Naval Hospital had physicians that weren't registered, you people wouldn't go there. Our President wouldn't go there. You know the cause. Please do something about it.

You, Ms. Sue Kelly, Representative, in your district, you have two VA hospitals. And both of them are going downhill. Both of them are going downhill. I'm not blaming you per se, but shouldn't you be looking into this matter?

Audience PARTICIPANT. That's why we're here.

Mr. MILEO. OK. You're here now. What are you people doing here today? You shouldn't be here. You elected these people to represent you. We should be home doing what we want to do. But we're here reminding them of the job that should be done. And I think it's wrong. I agree with you——

Mr. SHAYS. I'm going to interrupt you a second. I'm just going to interrupt you a second. I at least deserve the opportunity——

Mr. MILEO. All right.

Mr. SHAYS. You're going to get to speak a little longer, but I've just got to say to you we could have this hearing down in Washington and not have it here. We have it here at the request of the three Members who are by my side here——

Mr. MILEO. And I thank you people. [Applause.]

Mr. SHAYS. And we——

Mr. MILEO. I thank you. Congressman Gilman is a personal friend of mine. He's a good man.

Mr. SHAYS [continuing]. And because they wanted you to tell this committee firsthand what you feel and what you're thinking. So I just want you to know you can't have it both ways.

Mr. MILEO. OK. Congressman, please excuse me. He is a personal friend of mine. He's a good man. He's a decent man.

Mr. SHAYS. Well, don't get carried away. [Laughter.]

Mr. MILEO. Well, I lay it where it is. You people know the problems. All these people are telling you horror stories. You know that. Take their horror stories and go down there and fight for us.

I think there are some elected officials in this United States that care more for foreign veterans than American veterans. [Applause.]

We have two Senators in New York State. Moynihan, he doesn't even know what's going on. D'Amato, 2 years ago, he runs to the Baltic Sea playing hot stuff. Why isn't he representing we, the vet-

erans? Why are they running all over the world giving my money away and taxing us to death?

Audience PARTICIPANT. Because he's just faking it. That's why.

Mr. MILEO. No, I'm not going to call him a fake. I'm going to call him he's not eligible to do the job. Vote them out. Vote them all out. That's the only power we have left. And if you don't use it, then take it and I don't want to hear your cry anymore. Damnit, you've got the power of the vote. Unite and put these people out of business.

These people will go to the best hospitals in the United States. Bethesda Naval Hospital, I was there. When you walk in the door, "Yes, sir," "No, sir," "What's the matter, sir?" Get off my back. Just give me an aspirin.

I'm not here to pick on anybody. [Laughter.]

I'm here to set the—I've heard all your horror stories. They don't want to hear them anymore. They know what they are. Tell them to represent you. That's who they are, House of Representatives. That means they're supposed to represent you in Congress.

I don't want to be here today. I came here today. Can I tell you one short story while I'm here today?

Mr. SHAYS. I was just going to say you're——

Mr. MILEO. It will take a minute.

Mr. SHAYS. No. I know.

Mr. MILEO. It will take a minute.

Mr. SHAYS. You're going to talk. I just wanted you to know you're at your 3 minutes——

Mr. MILEO. Yes.

Mr. SHAYS [continuing]. In spite of the fact that I interrupted you.

Mr. MILEO. Can I talk 1 minute?

Mr. SHAYS. You've got 1 more minute.

Mr. MILEO. All right. Let me tell you what happened to me 38 years ago.

Audience PARTICIPANT. Did they give you a medal?

Mr. MILEO. I earned my medals. And I'm sorry what you went through.

Audience PARTICIPANT. The President gave my wife——

Mr. MILEO. I'm sorry what you went through.

Audience PARTICIPANT [continuing]. Two medals——

Mr. MILEO. Thank God.

Audience PARTICIPANT [continuing]. Posthumously.

Mr. MILEO. Thank God.

I'm going to tell you what happened to me 38 years ago. I'm going to talk a little low. Lloyd's Department Store was being opened up in the town of Newburgh about 38 years ago, Congressman? So my wife and I, my little boy are going there. And there was a veteran, an American Legion guy, selling poppies. And I'm walking by, he jammed it in my face.

And I say, "Sorry." I kept walking. I didn't have the money. You know, I'm raising a family, just got out of the Service, and et cetera. And he keeps following me. And that's all I remember. His name was Bill.

Of course, his buddy selling poppies on the other side said, "What's the matter, Bill?" "Oh, this guy don't want to buy a poppy. He must be 4F or he must be a deserter."

I took a verbal abuse. And I swore that day that I would never represent any vet. I don't belong to the American Legion or the VFW, which I break from both of them. I don't. They just turn me off. They gave me a verbal abuse and I was a "deserter," I was "4F," et cetera.

Mr. SHAYS. You got 1 minute. You used 1 minute.

Mr. MILEO. I'll be done. And I swore that day I would never represent or talk about veterans. Today is the first day I've done it. You know why? My brother-in-law, Al Roberts, took a plane today—he was treated in Castle Point—to Tucson, AZ. You know why? He couldn't be treated in Castle Point. His daughter set up a meeting in one of the VA hospitals in Tucson, AZ.

Mr. SHAYS. You need to wrap it up, sir.

Mr. MILEO. Right. Why does he have to fly to Arizona to get treatment? That's the question. This woman was 100 percent right.

Thank you. Congressman, please excuse me.

Mr. SHAYS. OK. [Applause.]

Sir, I want to make sure you sign. Sign the list after each speaker. Who's our next speaker?

Mr. NOVAK. Over here.

Mr. SHAYS. Yes. We're just going to go around the circle. Oh, over here? Yes, sir? Wait. Excuse me. I'm sorry, sir. I promised you. You're next right over here. Right over here. The mic, please, over here. The mic right there, please.

STATEMENT OF BILL NOVAK, VETERAN AND NEW YORK STATE BENEFITS PROTECTION OFFICER, DEPARTMENT OF NEW YORK DISABLED AMERICAN VETERANS, MIDDLETOWN, NY

Mr. NOVAK. My name is Bill Novak. I'm past aid commander of the Disabled American Veterans in New York. I'm on the National Executive Committee. And I'm the New York State benefits protection officer for New York State.

I'd like to start with veterans and their dependents have made enormous sacrifices and eminent contributions in the service of this Nation. Since the beginning of our Nation, it has, therefore, been the tradition to treat our veterans and their dependents as a special group, entitled to benefits above those available to the general civilian population.

While serving in our country's armed forces, veterans not only relinquish their liberty to allow the rest of us to continue to enjoy ours. They lose income and other civilian economic and educational opportunities, endure the rigors and hardship of military service, risk the hazards of war and dangerous military missions, and suffer injury and death. Of course, the heaviest burdens are borne by those who come back disabled.

Most Americans deem it improper to allow those who preserve our freedom at personal expense to bear the financial and other burdens resulting from military service. In recognition of what veterans and their dependents endure as a cost of the security to our Nation, our country has made a commitment, a restitution for

these sacrifices and contributions through indemnification for disabilities and other veterans' programs.

Our Nation's commitment to its veterans has endured periods of economic crisis and has evolved through many military conflicts. Although the consciousness of the needs of veterans may decline somewhat between periods of major conflict, the needs continue in the aftermath.

The American public strongly supports veterans' programs and expects the commitment to veterans to be honored. And I will support that with several polls that have been done, one of them by Harvard University and the Kaiser Foundation, that 93 percent of the American public oppose any cuts to veterans' benefits. And another one, the Harris Poll done by Business Week magazine, found that 75 percent of the American public oppose any dismantling of the VA.

Therefore, this Nation must continue to honor its obligation to care for the special needs of a special group of citizens. Because veterans are a special group, their programs should always have a priority for our Government. These programs must be adequately funded to assure they remain effective in fulfilling their purpose.

Unfortunately, there are some who would abandon this commitment and balance the budget on the backs of our veterans. How dare they send America's young men and women into harm's way and then say, "We can no longer afford to honor that commitment"? We must remain vigilant and oppose any attacks on our benefits.

Having said that, I would just like to make a few points. For over 11 years now, the independent budget that Mr. Demarco spoke about before has been sent to all Members of the Congress. It's a budget put together by the AMVETS, Disabled American Veterans, Paralyzed Veterans, and the Veterans of Foreign Wars. And it's endorsed by 50 other organizations and medical units and things like that. It has proposed ways to make the VA more efficient and save money for the government.

I find it interesting that they say that they weren't really aware of a lot of these things that VERA could impose because one of the——

Mr. SHAYS. Just to let you know, you're at 3 minutes.

Mr. NOVAK. OK.

Mr. SHAYS. You may keep going, but you're at 3 minutes.

Mr. NOVAK. OK. One of the comments that came out of this several years ago that was sent to the Congress—and these are comments from that independent budget. It says that, "Although the independent budget veterans' service organizations continue to support VA restructuring goals and advocate for operational change within the VA system, we fear that these efforts to be cost-effective may be overriding efforts to provide high-quality care." This came out over 3 years ago. They were advising Congress that that could happen.

I also found it kind of interesting that they admonished Mr. Farsetta before for saving that $148 million that they told him to save. They told him, "We're not going to give you the money. You've got to save $148 million." He did his job, and he's admonished for it. I find it kind of interesting.

Another thing, I heard a comment before. They said that the VA absolutely says, "We don't need any more money." there are comments from Secretary Brown or former Secretary Brown that said that, "If we maintain a straight-line budget for next year, we probably will be forced to deny care to 105,000 veterans and eliminate 6,600 health care positions."

These are all things that were said before. And now we're saying, "Oh, we don't need any more money." I think the bottom line is that the veterans have more than—everybody wants a balanced budget, and we think that's a priority for the Nation. But the VA budget makes up only 2 percent of our national budget.

Yet, the cuts in the VA program—and I can show you from over the last 2 decades—$2 billion in the 1980's, omnibus bill of 1990, $3.67 billion in cuts in veterans' program, 1993 omnibus reconciliation, $2.6, already $8.27 billion in cuts in the VA programs and with the President's current proposals, another $3 billion. By the year 2000, that's $11.25 billion.

And I think that if we want these people to maintain good programs in the hospital, you've got to give them the funding that was out there. And I see that the Congress is now finally—they've passed a resolution in the last year that they're going to be examined in that independent budget. And I hope that they will be working very hard to get the proper funding to the VA to get these programs.

And I thank you for the time.

Mr. SHAYS. Thank you, sir. [Applause.]

I just want to make sure everyone who speaks that we get a form just with your name and address for the transcriber.

Mr. SPADARO. It's been a long day.

Mr. SHAYS. Thank you. Your name and where you live?

STATEMENT OF BEN SPADARO, VETERAN AND VA EMPLOYEE, BRONXVILLE, NY

Mr. SPADARO. My name is Ben Spadaro. I'm from Westchester County, Bronxville, NY. My background has always been working for the VA after I came out of Service, after spending 9 years. I then went to become the county coordinator in Westchester County. I retired in 1990. I was appointed by President Bush to a committee in Washington.

And my statement is a 5-year plan approved by Congress to balance the Federal budget calls for the deepest cuts ever in VA programs. While tens of billions of dollars have been earmarked for new and expended Federal programs and to pay for these increases and $85 billion in tax breaks, the budget plan cuts the President's original request for VA funding by an average of 2.3 percent over 5 years. That's more than twice as much as the average of the 1 percent cut in other Federal programs.

There's no question that veterans want to put their physical house in order. But to balance the budget agreement unfairly burdens veterans' programs and severely hampers the VA's ability to provide quality health care.

Congress has an obligation to veterans to give sufficient funds to provide sufficient care to the VA and to cover the cost of the health

care. The Department of Veterans Affairs has over the last many years lost at least 40 percent of VA moneys.

And if you take into consideration what hospitals used to be—for instance, Montrose was a 2,000-bed hospital. It's now a 600-bed hospital; 1,400 beds have been cut. Every one of those beds are considered to be money. And this was at the beginning and at the Carter administration and to date.

Historically the VA has approximately $5,600 million a year. And that was just to pay for raises and the cost of medicine, supplies, and equipment. And I can go on and on.

The VA cannot continue to operate without sufficient funds. The Congressmen and Congress ladies—I had to add that today—will continue to see medical decline. The Congress must appropriate more moneys and not choke the VA officials if something is wrong.

Mr. SHAYS. I just wanted you to know your 3 minutes have come now.

Mr. SPADARO. I have about 10 seconds.

Mr. SHAYS. OK.

Mr. SPADARO. Without sufficient funds, more and more meetings such as these will occur.

Where does the problem originate? I would say from the Congress and from the several Offices of Management and Budget and from the Hill itself, not from the VA. Not one VA official voted for VERA. And the officials in charge of hospitals, they cannot continue without the moneys allocated properly to the VA.

Thank you very much.

Mr. SHAYS. Thank you very much, sir. [Applause.]

May I just see how many more speakers we have? Would you just raise your hands to see how many more speakers we have? Five? OK. Well, they keep coming up here. Yes. This list is growing. I'm getting a little concerned. We started out with seven. We still have seven.

Audience PARTICIPANT. I just need about a minute.

Mr. SHAYS. OK, sir. We're going to go there, and then we're going to come to you. You're ready. Let's go, Bob.

STATEMENT OF RAY PARRIS, VETERAN, WASHINGTONVILLE, NY

Mr. PARRIS. My name is Ray Parris, Washingtonville, NY. That's P-A-R-R-I-S.

Mr. SHAYS. Your address?

Mr. PARRIS. I've been going to Castle Point since 1980. First I started going for an artificial leg. I was not Service-connected, but the veterans would cover it. They had to send me to Manhattan.

After about my sixth visit, I noticed the color TV was gone. And I said, "What happened to the TV?"

They said, "Budget cuts."

I said, "Oh, well, no TV."

The next time I went down a few months later, I noticed the coffeepot was gone. I said, "What? No coffee?"

They said, "Budget cuts."

I said, "Oh, well."

A couple of years later when I went to go to the city, they said, "We can't send you any more because the government cut back.

You're not Service-connected. We can't give you a leg any more." I thought that sucked.

A couple of years ago I had a severe sore throat, could hardly swallow. I went to Castle Point for treatment, where I was informed by a snotty nurse that I should not have come right over but called for an appointment instead. She said you could only come if it was an emergency. I told her I thought that it was an emergency.

I insisted she contact my doctor, Dr. Martinko, which, after much aggravation on my part, she finally did. Dr. Martinko soon came down, gave me a thorough examination, and gave me antibiotics.

Dr. Martinko resigned a short time later. She was a great American doctor. She was smart, compassionate, and caring. I heard that she just couldn't practice medicine there anymore because of how it was run. As far as I and many veterans are concerned, she was the best doctor at Castle Point.

A large percentage of doctors are foreign-speaking. When they talk to me or I ask them a question, I cannot understand what they are saying with their heavy accent. This is not good.

A couple of times I've asked different doctors for medicine to relieve terrible stump pain. I'm an amputee. And they just prescribe me medicine for stomach pain. They didn't understand me.

Another time a doctor asked me when I last had an "addin" test. And I said, "Iron test?"

And he kept repeating, "Addin, addin." I finally realized he meant a urine test. Unacceptable. This failure to communicate is not good for patients' welfare.

I will state that an overwhelmingly high percentage of doctors at Castle Point, 70 percent or more, are foreign. And, whether they are competent or not, the language barrier creates a potential for disaster. Then they get an excellent doctor, like Dr. Martinko, who speaks good English, and they let her go.

Now we find that a lot of the doctors practicing at Castle Point are not New York State-licensed. This is not only totally outrageous, but should be criminal.

The wait at the pharmacy for prescriptions is 2 hours. Short staff they say. This is totally unacceptable to a sick veteran that just wants to get his medications, take them, go home, and lie down.

Also, they are slip-shod. I have had a draining abscess for over a year now and have to bandage it two or three times a day.

Mr. SHAYS. Sir, I'm just letting you know your 3 minutes have come.

Mr. PARRIS. I'll be done in 15 seconds.

The doctors write me prescriptions for four by four cover sponges. And the pharmacy keeps sending me four by four gauze. I've went to the pharmacy in person and showed them the difference between the two. The cover sponge is absorbent, and the gauze is not. It would soak right through and be useless. But the people just can't get that into their heads or they just don't give a damn.

Any politician that doesn't think that funds should be rerouted back here and the VA problems and concerns should be addressed and corrected should have themselves or their loved ones put into this VA system at Castle Point and see how they liked it under an alias, of course, with no publicity.

I'd also like to say there's lots of good doctors at Castle Point and excellent technicians and nurses. And I've had a lot of them. But there's a lot of bad ones, too, and you've got to look into it and correct it.

Thank you. [Applause.]

Mr. SHAYS. Thank you.

Sir to my right, you're on.

STATEMENT OF JOHN SKYLER, VETERAN AND DEPARTMENT COMMANDER, DEPARTMENT OF NEW YORK DISABLED AMERICAN VETERANS, CHEEKTOWAGA, NY

Mr. SKYLER. I'm John J. Skyler, the department commander for the Department of New York, Disabled American Veterans.

Why is it that lives have to be lost before Congress starts to ask questions? Staffing cuts will obviously have an impact on patient care. And cuts made too deep result in overworked staff that can't keep up and cannot give the basic care that human beings, let alone veterans, expect when they are hospitalized. Obviously VERA isn't working.

When you made these budget cuts, they look great on paper. But when it comes down where these cuts will actually be made, Congress has to realize that patients deserve quality care and enough staff to assure that care is received. Obviously Congress would have served the veterans better if they search elsewhere for places to cut, rather than where lives are at stake.

We should all applaud the employees and the families that have the courage to speak up and hope that these problems will stop. The veterans have already paid the price for freedom we all enjoy and take for granted. We would never have believed it. If we had known, we would have battled the enemy and survived only to come home so far after having battled the enemy of another kind and lose our lives.

Congress, this is your wake-up call. Do not allow this to happen at this facility or any other in this country. The veterans made this country what it is today and deserve better.

Thank you.

Mr. SHAYS. Thank you. [Applause.]

STATEMENT OF HELENE VAN CLIEF, VETERAN AND TREASURER, MILITARY WOMEN AND FRIENDS AND MEMBER, COALITION FOR FAIRNESS TO VETERANS AND VAVS, BRONX, NY

Ms. VAN CLIEF. My name is Helene Van Clief. I am from the Bronx, and I am a disabled vet. I want to thank you all for allowing me to speak. I am also a member of Military Women and Friends. I am the treasurer there and a member of the Coalition for Fairness to Veterans and VAVs.

The VA health care was originally set up to give health care for those who could not afford to pay and those who were disabled within the military. As it stands right now, if the health care for veterans goes down any further, women in the 1950's would have gotten considerably better care than veteran women now.

In Third World countries, women are seen by doctors for their medical care needs. They are treated for things that VA has never treated women for. An example of this would be pregnancy.

Two years ago women-specific pajamas was considered a major accomplishment for the health care of women veterans in Manhattan VA. Now women at the Bronx VA are seeing a nurse practitioner for their medical treatment.

There are a lot more women in the military now who will be getting out and looking for health care as they received in the military. With all of these cutbacks, what kind of health care can they suspect to find in the future?

Why do more and more women choose not to use the VA for their health care needs? When women are asked, "Are you a veteran?"; they usually answer, "No." Is this because they know how bad the health care is at the VA and there is no real benefit in saying, "I'm a veteran"? It is hard for women to use a system which does not give them total equal care as their male counterparts.

What kind of treatment can women who get out of the military expect to get in the future? What do women veterans get? I can only speak on my own experiences.

I was at the Women Clinic in the Bronx. I was seen there by that—there is a nurse practitioner. And she is the primary person. I had a mammogram, which was at the VA. And they sent me a postcard saying that I possibly had cancer. I was sent to the Cancer Clinic as a referral. And I went and got a second opinion.

The second opinion said, "I really don't think that there's anything wrong. I think you had a bad mammogram." Well, I opted to get a breast reduction and have a biopsy done on the tissue just in case. Since all my relatives of grandmother's family and my grandfather's family all had breast cancer, I was really afraid that, "Maybe they're right."

Mr. SHAYS. I just want you to know your 3 minutes have come. You may keep talking.

Ms. VAN CLIEF. I was an LPN, and I worked both at the Bronx VA and at Montrose. I worked there a long time ago. And at the time Montrose had a big problem with drugs. I don't know if they still have it and whether that was ever resolved. I worked also through the reserves at 24th Street VA Hospital, but that was a long time ago.

So I feel I know the system. And I do feel that some of these renovations need to occur like at the Bronx VA. When I was in the hospital for rehab, there was no female bathroom in that section. You either had to go across the way to the Psych Department or ride the elevator up—like at the time I think my room was on the seventh floor—ride up about five floors just to go use the bathroom.

How many veterans have to die before something is done? The VA at the Bronx was only built 20 years ago. Does so much renovations there for so—there is no money left to pay for staff. How much do we cut back before patients suffer?

There were a lot of psychiatric patients who were doing extremely well at the Bronx VA and now due to cutbacks are forced out of that longer treatment into a shorter treatment.

For a majority of women veterans saying, "I am a veteran" means substandard health care and no place to go. [Applause.]

Mr. SHAYS. Thank you very much.

We have three speakers, and then we're concluding? Sir, you're going to end up. All right? OK. Yes, sir.

STATEMENT OF SILVIO MANGIERI, VETERAN, WALKILL, NY

Mr. MANGIERI. My name is Silvio Mangieri. I'm 83 years old. I saw service in Germany. And I want to speak because during these hearings I haven't heard what I feel is most important.

I wish to implore and impress our Congressmen that what I feel is more important and more needed is a change of direction, not to look for redress of faults or corrections of their faults because for many years all I've heard from the Government is excuses and ways of growing your mind with facts and figures.

Mr. SHAYS. Sir, would you just tell me what town you're from? I didn't ask you that. Tell me your town, where you're from.

Mr. MANGIERI. Oh, yes. I wasn't aware of that, sir.

Mr. SHAYS. Where are you from? Where is your community? Where do you live?

Mr. MANGIERI. I live right here in Walkill.

Mr. SHAYS. Thank you.

Mr. MANGIERI. I would like to impress our Congressmen that what we need is aggressive, radical action. What we need is for the States to have something to say about the jurisdiction in the quality care that our veterans are receiving in the hospitals within our area.

They need to have a greater say over what is done and what is required for them, what doctors and nurses should be in the hospital and the rest of the technicians and the rest of the medical staff.

In this respect, I feel that Washington has grown to be too big a bureaucracy as far as the Veterans Administration is concerned. And they are too far removed now and distant from the 50 States and their territories.

I can't see how they could respond to the problems of the veterans in the many hospitals throughout the country. They need to be done on the spot by the people who are taking care of them right there and then. That is what I feel should be done.

Thank you.

Mr. SHAYS. Thank you very much. [Applause.]

You're on, sir.

STATEMENT OF ROBERT IANAZZI, VETERAN AND VIETNAM VETERANS OF AMERICA AND DISABLED AMERICAN VETERANS, MIDDLETOWN, NY

Mr. IANAZZI. My name is Bob Ianazzi. And I'd just like to say I——

Mr. SHAYS. And you're from?

Mr. IANAZZI. I'm from Middletown.

Mr. SHAYS. Thank you, sir.

Mr. IANAZZI. And I served with the Fourth Infantry Division over in Vietnam in 1966. And during the month of May was our worst month. We had heavy casualties. And we had over 200 people killed and wounded. And at the time it was not an easy sight to see. I'd just like to say that I've never forgotten it. I've been going to Montrose VA now for the last 4 years for treatments for it. I'm 60 percent disabled.

I've gone down to New York City for hearings, and I submitted new evidence that a VA—which seemed to be totally overlooked.

They took it, and it seemed like they just shuffled it to the side. And then I got a letter saying that I was denied my increase in my disability.

I just want to say that the way the VA is going right now we need all the help we can get as far as Castle Point and Montrose VA. We don't need anybody to get a $16,000 bonus to shut us down. I think that's appalling.

I've always been proud of my country. I fly a flag every day, both POW and the American flag. And I'm proud of my country.

Thank you.

Mr. SHAYS. Thank you, sir. [Applause.]

I'm getting a little confused. I thought we had one last speaker. How many speakers do we have left? Do we have you, sir? Wait a second. Wait a second. We have three still?

I'm going to just say I want all three to stand. I want us all to see who our last three speakers are. Thank you very much, sir. No, no. No. You can't go over that way. We've got one there, one there, and one there. And then we're going to conclude.

Thank you, sir. You may begin.

STATEMENT OF GUY CROWTHER, VETERAN, PORT JERVIS, NY

Mr. CROWTHER. I'm Guy Crowther from Port Jervis, NY. This was written preferably to represent Gilman, and I'd like to ask him to strike the last word, please.

OK. I know this meeting is primarily the situation that has occurred at Castle Point, and I believe that what I have to say is of as much additional concern to the veterans gathered here today.

I was watching C–SPAN this past Wednesday night when the appropriations for the fiscal year of 1998 were being discussed. And it sure made my mind go at a whirl when I heard in the amounts of tax dollars that were being allotted to countries outside our borders.

And Representative Gilman is the head of the International Relations Committee. That's why I've got this. It says when I heard of $100 million to the IMF and then about $85 million to some Asian group. There was also several authorizations to other foreign groups that were not to exceed somewhere over $1 million.

What I'm bothered by is why our hard-earned moneys, a lot of which is paid by those here today, is going into the slush fund to many countries that are reaching out with one hand for a handout and stabbing us in the back with the other.

I would like to know what the so-called discretionary fund is that is authorized for the administration. It is not said by the media or the Congress or admitted that the present administration does not like this United States. They would like to see the United States become a bank book for the world with no say by the citizens of the United States. And they are actively pursuing the one-world government philosophy. This information is being revealed by some of the independent think tanks and other groups of this Nation.

I would also like to know what has been done about the situation with the Panama Canal treaty that I talked to you about at the Port Jervis meeting. I know that the House of Representatives are not directly involved in the treaties, but have you ever talked to our State Senators about this concern? I know the veterans gath-

ered here today sure have a big concern about the movement of our warships between the oceans around our country.

Finally, sir, I would like very much to know why you support the killing of almost 40 delivered babies in the delivery, which is unnatural anyway.

Thank you for your time.

Mr. SHAYS. OK, sir. I just need—[applause]—hold on 1 second. Bear with me 1 second here. I have three speakers that I've missed in the transcriber. Your name again is?

Mr. CROWTHER. Guy Crowther.

Mr. SHAYS. Bob, do you have his card? We need your card. Did you sign a—is it one of these three? Who was the gentleman who spoke just before this gentleman? Your name is?

Mr. IANAZZI. Bob Ianazzi.

Mr. SHAYS. I'm sorry? Bob?

Mr. IANAZZI. Ianazzi.

Mr. SHAYS. Ianazzi. Thank you, sir.

And the gentleman who spoke before Bob is? Silvio?

Mr. MANGIERI. Silvio Mangieri.

Mr. SHAYS. Thank you.

And the gentleman who spoke before Silvio?

Ms. KELLY OF NEW YORK. That was a woman, Helene Van Clief.

Mr. SHAYS. Helene Van Clief. OK.

And Dick Pinckney?

Mr. PINCKNEY. Pinckney.

Mr. SHAYS. You're ready to speak now? Is that who we're going to next?

STATEMENT OF RICHARD PINCKNEY, VETERAN, MIDDLETOWN, NY

Mr. PINCKNEY. Yes. This should be very short. I want to compliment the people that held this meeting today. And I just feel that it's after the fact and it should have been before the fact. Some of the great information that we got here today has been the same information that we've had for many years.

I also want to say that I was down in Florida, the State of Florida. I found a full page of the Tampa Times down there. I took it and mailed it out to Congresspeople.

My post—my name is Richard Pinckney, a past Commander of Post 151, right here in Middletown. My post received a letter back from a Congressperson addressed to Jake Volo saying they were going to look into this. My name is not Jake Volo, and Jake Volo has been deceased for 5 to 6 years. I just think we fell asleep someplace along the line and we should get going.

I think over there they brought—and I would like an answer to this eventually. They brought in new PXes. I've been around the country in VA hospitals on visitations. The PX we have over there sells frying pans, cooking equipment for $59.95. I just don't understand what a patient in a VA hospital would be doing buying $59.95 cooking utensils.

I also wonder to myself because I've been to Lebanon, PA. I've been upstate New York to one of the Finger Lakes. I've been to Charleston, SC. I've been to all our veteran hospitals around here. I lost my brother in a veterans' hospital. My other brother is 100

percent disabled from World War II, both of them. And I just wonder.

Let me say this. I want to thank Dick Mayfield and Congressman Gilman for calling me when there are meetings over to Castle Point. And I go there. And I want to thank them both for that.

I found out the last meeting I was over there to, I found out that any moneys from Medicare or Medicaid that Castle Point Hospital gets has to be turned back over to the general fund. Is that right? The hospital gets no benefit from it. They furnish the medicine, the prescription, the doctors. Your Medicare goes back into a general fund. I don't know what that means. I would think it's the U.S. Government's general fund.

And I also have one other question that the man down here brought up, one of the men brought up, about sending the vessels into the air and all of that. I wondered with all the cuts on VA why the cuts to Bosnia had not been downed, they had been upped.

And I want to thank you for your time. And when I walked in here, this place was absolutely filled with interested people. And I think some of them have left in a haste.

Thank you. [Applause.]

Mr. SHAYS. Let me just say it's so wonderful that you all have stayed. And I realize that some had to go. So we do know this was an extraordinarily well-attended hearing.

Mr. Crowther, you have the last word. Oh, I'm sorry.

Mr. PRESSLEY. Name is——

Mr. SHAYS. Pressley. I'm sorry. I apologize.

Mr. PRESSLEY. That's quite all right.

Mr. SHAYS. Let me get it correct. Your name is Hugh Pressley, Jr., and you're from the Bronx?

Mr. PRESSLEY. Correct, Bronx, NY.

Mr. SHAYS. It's nice to have you here, sir.

Mr. PRESSLEY. It's glad to be here.

Mr. SHAYS. Thank you for coming.

STATEMENT OF HUGH A. PRESSLEY, JR., VETERAN, BRONX, NY

Mr. PRESSLEY. I've got a couple of questions I'd like to ask. One, is it possible that this can be continued also in the city because there are a lot of veterans that are being heard here and there's a lot more that I know that want to be heard in the city? You get a tremendous turnout because they have a lot of issues as well.

I'm a veteran, aerial veteran, of Vietnam. I served for 2 years. I came back. I did my time, had a job, the whole nine. And recently I've become homeless.

And I've noticed not none of the homeless veterans have been represented or even heard from. A lot of these organizations that's out here, they're claiming to represent veterans, but they're not. All they're interested in is numbers. And the minute you have a gripe or you have a problem, whatever the case may be, you're shoved to the side or they tell you, "Well, you've got a problem. We'll get to it." And it would be real nice if that would be looked into.

Also I think if anybody is going to represent us, they should at least be a veteran. That should be one of the criteria for representing a veteran, especially if you're in a position where you're

going to be taking funds from the veterans. You ought to at least know some of our needs before you start taking our funds.

That's all I've got to say.

Mr. SHAYS. Thank you, sir. [Applause.]

Before we conclude this hearing, I want to thank the Town of Walkill; in particular, the police department. It started out rather ominously for me. When I walked in, the police officer said that he wanted to make an announcement to tell you all that you needed to be under control. I thought, "My God. I don't usually have a police officer opening my hearings telling you all not to riot."

I'd also like to thank our court reporter, Ed Johns, for helping us out today; and our sound system, Jim and Greg of Thunder Sound Productions; and also our clerk, Jared Carpenter.

We're going to conclude by my thanking you for being here, for your patience during the day. We got through it quite well. And I learned that you guys are in charge and I just have to follow orders.

Audience PARTICIPANT. That's right.

Mr. SHAYS. It took a while for me to get that.

At this time I'm going to recognize Sue Kelly.

Ms. KELLY OF NEW YORK. Thank you. I really want to thank you all for staying as long as you have.

The purpose of this, as I said before, is to try and help all of us to understand the net effect of VERA on the veterans in this area. We want to make sure that we get for our veterans high-quality patient-centered health care. I believe that we can do that. I believe it's something that is available to us if we just all work together.

And we needed the input we heard today. We will do something with it on Capital Hill, I guarantee you. Congressman Shays is here to prove that.

Thank you.

Mr. SHAYS. Thank you. [Applause.]

At this time I'd like to call on Maurice Hinchey. And then we'll go to Ben. Thank you.

Mr. HINCHEY. Well, Chris, I just want to thank you for coming over here from Connecticut and holding this hearing. I want to thank Ben Gilman for initiating it. I think it has been very interesting and informative. And I want to thank all of you who have been here for the duration as well as everyone who spoke and left. I think it has been a productive afternoon. I'm very glad that I had the opportunity to be here.

Now we have to make sure that the Veterans Administration, first of all, has the funding it needs to carry out its responsibilities and, given that funding, that it does the job it's supposed to do.

Thank you very much.

Mr. SHAYS. Thank you. [Applause.]

And, Mr. Gilman, sir, you have the last word.

Mr. GILMAN. Well, Chris Shays, we thank you for bringing the committee to Orange County so that Sue Kelly and Maurice Hinchey and myself could bring our veterans together and get the benefit of their thinking and share their views.

We're so thankful that Jim Farsetta from the region and Mary Musumeci—did I get it right that time, Mary—and Mr. Sabo have

stayed throughout to listen, to learn. And Dr. Wilson is still here also. I didn't notice Dr. Wilson staying that long. But these are the key people. And they have heard your views.

Your Congressmen and Congresswoman have heard your views. We're going to put them to good use now as we meet further with our regional directors and the veterans' officials to make certain that we try to correct some of the imperfections and try to work together to preserve two good hospitals that we all have a great deal of pride in: Castle Point and Montrose.

Now, I can't thank you enough, those of you who have lingered this long to give us the benefit of your thinking. And to our staffs who are here, we thank you. And our police officers, who have helped us to try to keep a little orderly conduct here, we appreciate your sticking with us.

Chris Shays, we can't thank you enough for coming all the way over from Connecticut to conduct this hearing. And we really appreciate everyone's partaking in this issue.

Thanks for being here. And God bless.

Mr. SHAYS. Thank you. [Applause.]

God bless. This hearing is adjourned.

[Whereupon, at 6 p.m., the subcommittee was adjourned.]

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