

VA HEALTHCARE IN THE NEXT MILLENNIUM

HEARING

BEFORE THE

SUBCOMMITTEE ON NATIONAL SECURITY,
VETERANS AFFAIRS, AND INTERNATIONAL
RELATIONS

OF THE

COMMITTEE ON
GOVERNMENT REFORM

HOUSE OF REPRESENTATIVES

ONE HUNDRED SIXTH CONGRESS

SECOND SESSION

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VA HEALTHCARE IN THE NEXT MILLENNIUM

MONDAY, APRIL 10, 2000

HOUSE OF REPRESENTATIVES,
SUBCOMMITTEE ON NATIONAL SECURITY, VETERANS
AFFAIRS, AND INTERNATIONAL RELATIONS,
COMMITTEE ON GOVERNMENT REFORM,
Peabody, MA.

The subcommittee met, pursuant to notice, at 10 a.m., at the Peabody Memorial Veterans High School, 485 Lowell Street, Peabody, MA, Hon. Christopher Shays (chairman of the subcommittee) presiding.

Present: Representatives Shays and Tierney.

Staff present: Lawrence J. Halloran, staff director and counsel; Kristine McElroy, professional staff member; Jason Chung, clerk; and David Rapallo, minority counsel.

Mr. SHAYS. This hearing will come to order and welcome our witnesses and guests and ladies and gentlemen, I invite you to please rise as the Peabody Air Force Junior ROTC Color Guard posts the colors.

Today, we came here to listen and to learn from those with a direct stake in the future of veterans' health care in New England.

This is our third hearing on the impact of reorganization and funding shifts on the availability and the quality of care in Department of Veterans' Affairs [VA] facilities. Earlier testimony described long waits for access to specialists, lapses in health care standards and funding inequities within and between regional Veterans Integrated Service Networks (VISNs). VA officials said facility restructuring here in VISN-1 and refinements in the Veterans Equitable Resource Allocation [VERA] system would, in time, bring improvements.

But last July, Congress' auditing agency, the General Accounting Office [GAO], concluded VA could be wasting \$1 million or more every day critical health care restructuring decisions are delayed. Today, more than 8 months, or \$263 million later, GAO still reports the VA "has been unsuccessful . . . in its efforts to design a capital asset realignment process."

So a significant portion of the \$1.7 billion Congress added to the Veterans Health Administration budget this year may be spent operating and maintaining unneeded facilities, rather than enhancing access and improving the quality of needed health care for veterans.

The effects of delaying the hard decisions in Washington are felt acutely here in New England. An older veterans' population, declining in numbers, but now in need of more extensive, more expen-

sive, health interventions, cannot wait years, or drive hundreds of miles, for the basic care to which they are truly entitled. Today we need to talk candidly and objectively about how the VA can sustain and improve a health care system in New England that will meet veterans' needs in the new millennium.

I want to thank Congressman John Tierney for inviting the subcommittee to the Sixth Congressional District of Massachusetts. We value his participation in this committee as an equal partner with the chair. We value this opportunity as well to discuss these important issues with those most directly involved, and we look forward to the testimony of all of our witnesses.

John, I would like to personally thank you for asking us to come here and this committee oversees all of the VA, all of DOD, all of FEMA, all of terrorist activities at home and abroad and when I asked John what hearing was most important he said we needed to talk about the VA and to meet in his district and that is why we are here. We will do a lot of good listening today.

John.

[The prepared statement of Hon. Christopher Shays follows:]

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INDEPENDENT

Statement of Rep. Christopher Shays April 10, 2000

Today, we came here to listen, and to learn from those with a direct stake in the future of veterans' health care in New England.

This is our third hearing on the impact of reorganization and funding shifts on the availability and the quality of care in Department of Veterans Affairs (VA) facilities. Earlier testimony described long waits for access to specialists, lapses in health care standards and funding inequities within and between regional Veterans Integrated Service Networks (VISNs). VA officials said facility restructuring here in VISN-1, and refinements in the Veterans Equitable Resource Allocation (VERA) system would, in time, bring improvements.

But last July, Congress' auditing agency, the General Accounting Office (GAO), concluded VA could be wasting \$1 million or more every day critical health care restructuring decisions are delayed. Today, more than eight months, or \$263 million later, GAO still reports the VA "has been unsuccessful ... in its efforts to design a capital asset realignment process." So a significant portion of the \$1.7 billion Congress added to the Veterans Health Administration budget this year may be spent operating and maintaining unneeded facilities, rather than enhancing access and improving the quality of needed health care for veterans.

The effects of delaying the hard decisions in Washington are felt acutely here in New England. An older veterans population declining in numbers, but now in need of more extensive, more expensive, health interventions, cannot wait years, or drive hundreds of miles, for the basic care to which they are entitled. Today we need to talk candidly and objectively about how the VA can sustain and improve a health care system in New England that will meet veterans' needs in the new millennium.

I want to thank Congressman John Tierney for inviting the Subcommittee to the Sixth Congressional District. We value this opportunity to discuss these important issues with those most directly involved, and we look forward to the testimony of all our witnesses.

Mr. TIERNEY. Thank you, Mr. Chairman, and I want to thank everybody that has taken the time today to join us here at the hearing.

I want to be the first to officially welcome Congressman Chris Shays to join us in this particular district and I can say that we have a Congressman here as chairman of this committee who is truly a person that we can work with and who understands these issues and works very hard on them.

I want to also welcome our witnesses from the Veterans' Administration, Dr. Murphy, Dr. Post and Mr. Conte with whom we worked with many, many times, as well as the veterans' agents from the surrounding areas who will also be testifying in the second panel. I am glad that you could all be with us and join us today.

Let me also welcome all the veterans in attendance and the veterans service organizations who have provided written testimony for the record. It is imperative that we hear your concerns and your viewpoints today. I look forward to listening to your comments after the first two panels have concluded and you will see that we have microphones in the aisles and that we will have an opportunity for folks to make comments and ask some questions.

Mr. Chairman, I have a written statement from Representative Anthony Vera, the State Representative from Gloucester that I would like to ask be presented in the record. And I also have a written statement from Mayor Nicholas J. Costello, the mayor of Amesbury which I would like to ask be put in the record, as well as a written statement from Congressman Thomas Allen of Maine, which I believe is already in there and ask that you enter that in the record.

Mr. SHAYS. Without objection, so ordered.

Mr. TIERNEY. I would like to acknowledge and welcome Mayor William Scanlon from the city of Beverly who is also with us in the audience today who has been a great friend of veterans and a number of other veterans' agents who will not be testifying, but with whom my office works on a regular basis and provide great service to the veterans in this District.

In Washington, veterans' health care is often analyzed as an issue of national scope, focusing on the processing, reengineering, streamlining initiatives and appropriations debates. Discussing the issue in this way sometimes removes and detaches policymakers from the concerns of individual veterans, veterans who live with the system on a daily basis, veterans who rely on the system for their most essential health care needs.

That is why I am particularly gratified today to have a hearing analyzing the local point of view. In many ways, health care is rooted in local systems and infrastructure, so it behooves us to extract ourselves from the daily Washington processes to come here today and to analyze the issues from a different perspective, yours.

For veterans in the Sixth Congressional District of Massachusetts, the facility that provides the primary and specialized medical care is the Edith Nourse Rogers Memorial VA Medical Center in Bedford. This institution has been providing care to veterans since 1929. It has always been a VA facility and last year it handled more than 186,000 visits.

Today we have with us Mr. William Conte, the director of the facility who will provide additional background on the facility's capacity and his efforts to deal with shrinking budgets.

A recent development, and one in particular that I am very excited about is the establishment of community-based out patient clinics. We now have two, one in Lynn and one in Haverhill. They greatly increase veterans' access to health care. These clinics are important to the effort to reach out to veterans and to serve them in the communities in which they live. We have helped to move forward the application of a third CBOC in Gloucester.

Last year, the Lynn and Haverhill CBOCs handled more than 5,600 visits and I know the representatives on the panel will be able to respond to questions about those clinics.

Although these are positive developments, there are also a number of challenges, both for veterans and the system that serves them. Transportation, to and from VA facilities is a primary concern. Again, the clinics are extremely valuable in extending VA's outreach to other areas, but for veterans who need specialty care or report for multiple visits, transportation hurdles may be too great to overcome.

I understand that if veterans go to one or two clinics, they can catch a shuttle to the Bedford facility if they need x-rays or other services not provided at the clinics. If they need more specialized services, however, such as an upper GI endoscopy, they may have to take another shuttle still into Boston.

For veterans, the current transportation process can be insurmountable, especially if it involves anesthesia or other procedures that complicate traveling alone. I hope we can discuss transportation concerns today, both at the regional and the local levels.

Long term care is also an issue that is gaining significance. VA has highlighted outpatient solutions and in-home care, which have their own advantages. If VA can assist veterans without uprooting them from their homes, this solution benefits everyone involved. My concern, however, relates to veterans with degenerative and other conditions that eventually may require hospitalization and inpatient treatment.

VA is now in the process of downsizing its inpatient capacity as it redirects assets toward outpatient care. So how will short-term shift affect the extended term outlook? How will VA be able to deal with the increasing demand of long-term care when the baby boom generation moves into this stage? And how do these concerns relate to VA's ability to comply with the Millennium Health Care and Benefits Act?

These are just a few of the issues I hope our witnesses will address today, and although I know there are many more of interest to the veterans in attendance, I look forward to hearing their testimony also.

Before concluding, let me just extend my thanks to several people from Veterans Memorial High School here in Peabody who have helped to make this hearing possible: Principal Joe Patuleia, Elaine Kirby, Richard Carey, Major Grover, of course, and the students of the culinary arts and the Air Force Junior ROTC.

In addition, I would like to thank the Peabody Police Department and Temple Beth Shalom for allowing us to use their parking lot.

I would also like to recognize Michael King, who is the director of the North Shore Veterans Counseling Services, for his dedicated service to our country and for keeping our North Shore veterans informed about the timely issues in his veterans' column in the Salem Evening News.

Finally, I would like to thank Chairman Shays again for calling this hearing. As I mentioned, I think this type of local focus adds immeasurably to our ability to address these issues. It is a special privilege to have the opportunity for the subcommittee to address issues specific to my own district.

I appreciate your willingness, Mr. Chairman, to hold this hearing today in Peabody. I especially commend you for all the work that you do in addition to veterans' issues with the very serious matter of terrorism and preparedness in this country for any event that may occur and I look forward to today's hearing.

Thank you.

[The prepared statement of Hon. John Tierney and the information referred to follow:]

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INDEPENDENT

Representative John Tierney
Opening Statement

"VA Healthcare in the Next Millennium"
Field Hearing — Peabody, Massachusetts
April 10, 2000

Subcommittee on National Security, Veterans Affairs, and International Relations
Committee on Government Reform
U.S. House of Representatives

Thank you Mr. Chairman, and let me be the first to officially welcome you to Massachusetts. Welcome also to our witnesses from V.A. — Dr. Murphy, Dr. Post, and Mr. Conti — as well as the veterans agents from the surrounding areas, who will be testifying in the second panel. I am glad you all could be with us today. Let me also welcome all of the veterans in attendance, and the veterans service organizations who provided written testimony for the record. It is imperative that we hear your concerns and your viewpoints today, and I look forward to listening to your comments after the first two panels have concluded.

In Washington, veterans' health care is often analyzed as an issue of national scope, focusing on process re-engineering, streamlining initiatives, and appropriations debates. Discussing the issue in this way sometimes removes or detaches policy-makers from the concerns of individual veterans — veterans who live with the system on a daily basis, and veterans who rely on this system for their most essential health care needs.

That is why I am gratified today to have a hearing analyzing the local point of view. In many ways, health care is rooted in local systems and infra-structure. It behooves us to extract ourselves from the daily Washington processes, to come here today, and to analyze the issues from a different perspective — yours.

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One recent development that I am very excited about is the establishment of community based outpatient clinics (CBOCs). We now have two — one in Lynn and one in Haverhill — that greatly increase veterans' access to healthcare. These clinics are important in the effort to reach out to veterans and serve them in the communities in which they live. We have helped to move forward the application of a third CBOC in Gloucester. Last year, the Lynn and Haverhill CBOCs handled more than 5,500 visits, and I know representatives on panel one will be able to respond to questions on clinics.

Although these are positive developments, there are also a number of challenges, both for veterans and the system that serves them. Transportation to and from V.A. facilities is a primary concern. Again, the clinics are extremely valuable in extending V.A.'s outreach to other areas. But for veterans who need specialty care or report for multiple visits, transportation hurdles may be too great to overcome. I understand that if veterans go to one of our two clinics, they can catch a shuttle to the Bedford facility if they need x-rays or other services not provided at the clinics. If they need more specialized services, however, they may have to take another shuttle into Boston. For veterans, the current transportation process can be insurmountable, especially if it involves anesthesia or other procedures that complicate traveling alone. I hope we can discuss transportation concerns today, both at the regional and local levels.

Long term care is also an issue that is gaining significance. V.A. has highlighted outpatient solutions and in-home care, which have their own advantages. If V.A. can assist veterans without uprooting them from their homes, this solution benefits everyone involved. My concern, however, relates to veterans with degenerative and other conditions that eventually may require hospitalization and inpatient treatment. V.A. is now in the process of downsizing its inpatient capacity as it redirects assets toward outpatient care.

- How will this short-term shift affect the extended term outlook?
- How will V.A. be able to deal with the increasing demand of long-term care when the baby boom generation moves into this stage?
- How do these concerns relate to V.A.'s ability to comply with the Millennium Health Care and Benefits Act?

These are just a few issues I hope our witnesses address, although I know there are many more of interest to the veterans in attendance. I look forward to hearing their testimony.

Before concluding, I would like to extend my thanks to several people from Peabody Veterans Memorial High School who helped to make this hearing possible:

Principal Joe Patuleia,
Elaine Kirby,
Richard Carey,
Major Grover,
the students of the culinary arts, and
the Air Force Junior ROTC.

In addition, I would like to thank the Peabody Police Department and Temple Beth Shalom for allowing us to use their parking lot.

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Thank you, Mr. Chairman.

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Testimony of Representative Tom Allen
April 10, 2000
Committee on Government Reform
Subcommittee on National Security, Veterans Affairs and International Relations

Mr. Chairman, thank you for holding this hearing to examine the delivery and quality of health care in VA facilities. I am pleased you are bringing to light some of the significant problems veterans face across VISN 1, and specifically in my district at the Togus veterans hospital in Togus, ME.

In 1997, the VA implemented the Veterans Equitable Resource Allocation (VERA) formula, which has since severely impacted veterans health care in the Northeast. There is simply no excuse for the hurdles our veterans must now face to access high quality health care. I understand that VERA has benefitted certain regions of the country, but the level of care in those regions has been raised on the backs of Northeast veterans.

The quality of care at Togus is extremely high. There is no question about it. If you can get in to see a doctor, the care is exceptional. The doctors and nurses have dedicated their careers and lives to serving this population and recognize the unique care veterans need.

However, the waiting time for an initial appointment is unconscionable. Some veterans wait more than six months for their first visit. The excessive waiting time makes it very difficult to enroll new patients. Because funding increases through VERA are tied to the number of patients seen and lower costs per patient, veterans in Maine are put at an automatic disadvantage.

I understand that the landscape of all healthcare across the country is changing. I see the benefits of converting from an inpatient to outpatient based system encouraged by the VERA model. However the conversion to this model, for various reasons, is hitting the Northeast VA facilities hardest.

Community Based Outpatient Clinics (CBOCs) are part of the solution to the problem. The CBOCs provide veterans with quicker and easier access to care closer to home. The clinics will undoubtedly increase the number of veterans served and also decrease the average cost per patient.

Allen Testimony, Page 2

I commend the leadership of VISN 1 for aggressively seeking approval for new CBOC authority. I was pleased to attend the opening of a new clinic in Saco, ME. Veterans in Southern Maine will no longer have to make the long drive up to Togus.

In Maine, we have one hospital for a state larger than each of the other five New England states put together. I think the CBOC model can make a real difference in a state like Maine and throughout the VISN.

But while the Northeast continues to make this critical transition, veterans fall through the cracks. I am told over and over by the VA Undersecretary for Health, Dr. Thomas Garthwaite, that the numbers in VERA work out. I am told that each VISN receives the appropriate amount of money to cover their costs. The formulas assume the cost of care as well as other factors: labor, patient mix, research and education, equipment and non-recurring maintenance. The averages may work out on the macro level, but they are not working out here in Massachusetts or in Maine.

I am convinced that VERA is flawed. The formula does not consider enough factors. One of the reasons it costs more to deliver care in Northeast hospitals is because our facilities are inefficient and frankly, in a state of disrepair. In fact, the former Acting Director of VISN 1 recently said, that over the past few years equipment and construction funds were used to supplement funds for direct medical care. Because the VISN and hospital directors did not or could not make the care changes as quickly as VERA required, the allocated medical care funds were insufficient.

It is easier and costs a lot less to implement new streamlined care lines at a brand new facility like the one in Bay Pines, FL, than it is at the oldest existing VA facility in Togus, ME.

Blame for the New England Network budget shortfall lies at all levels: the facility, VISN and headquarters. But the VISN is now stuck. They are in a position where it is difficult to receive increased funds because the facilities cannot handle an increase inpatient load and decrease costs at the same time.

The cost-cutting tool the VISN has is called a Reduction in Force/Staff Adjustment (RIF). RIFs have been proposed at every hospital in the New England Network. I recognize the fact that abolishing certain non-medical positions or overstaffed medical positions may be the correct course. But I object to the VA proposing a RIF and not proving how the adjustment will make direct medical care better. They must tell us how these people will be moved into new positions and what new positions will be created.

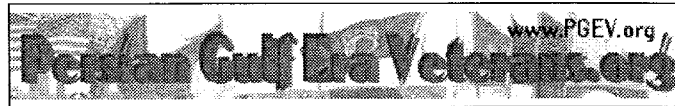
Can some of the people in positions that may be cut be transferred to the CBOCs? As I stated earlier, these clinics are a great idea, but the small staff at the Bangor clinic can barely keep up with the demand. If the clinics are not fully staffed, they create more problems. It seems irresponsible to me to begin staff cuts without properly assuring all the stakeholders how this

Allen Testimony, Page 3

makes the situation better. Communicating with veterans so they understand how staff will be realigned is central to their trust in the plan.

Despite past financial problems in the VISN, we must move forward. I believe the new VISN Director, Dr. Jeannette Chirico-Post, has the best interests of the VISN in mind. But I urge members of this committee to push officials at every level of the VA to look seriously and carefully at the problems in the Northeast. I urge them to look beyond the VERA formula, and find out why the outpatient transition is taking so long.

The VA must begin to provide some real leadership and guidance all the way down to the facility level if we are going to solve this problem. The veterans deserve no less.



Before the
Subcommittee on National Security, Veterans Affairs
and International Relations of the House Reform Committee

Statement of Venus-val Hammack
PGEV Women Liaison
North Shore Veterans Counseling Service
Gulf War Coordinator

Peabody Veterans Memorial High School
Peabody MA 10 April 2000

Mr. Chairman and members of the Subcommittee, thank you for the opportunity to present the views of the Persian Gulf Era Veterans - North Shore Chapter with regard to VA health services restructuring and resource allocation on the delivery and quality of care.

Projections are needed in the process to ensure that locally made decisions are not generated purely by cost reduction incentives to the detriment of the veteran patient and the VA system as a whole.¹

Issue

In Maine, it means veterans ride for four hours from Boston with post-operative sepsis because the Togus VA can not afford to do the surgery there, while space in Togus remains empty.²

Issue

Why is this the case?????: Under current law, however, coordination of payments between the VA and other federal and private health care program is not permitted. This causes serious hardships for many veterans who live far from VA inpatient facilities..³

1. Gordon Mansfield, Executive Director PVA 05 April 2000 statement

2. Jacqueline Garrick, Deputy Director National Veterans, AL, 05 April 2000 statement

3. Representative Dave Weldon (Florida 15) , 05 April 2000, Subcommittee on Health



Persian Gulf Era Veterans

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Central Sub-Region Mini MAC
VHA VISN 1 Clinical Board

Distribution:
Chief of Staff and Director of Nursing Service
Administrator for Patient Care Support, Education Coordinators (each)
Bedford, Boston, West Roxbury, Brockton, Northampton, Springfield

Q: How can the VA medical staff of this area properly treat gulf war veterans when the educational training on this population is not up on GW guidelines?

Comment:
It appears when the VA Educational Service distribute a Review booklet on Gulf War Health [25 pages] with quiz booklet for feed back to patient care providers (doctors/nurses) to complete - that the associated binder Guideline book [135 pages] would be distributed for full access and review.

This does not appear to be the current situation. Veterans of this organization have been told by doctors and nurses that they have never seen the larger Gulf War Health Guideline document.

This is a short change of information. Calling facilities in this area we have been told that there is a total of 3 Gulf War Health Guideline binders per Medical Center.

The valuable details which is contained in this document is NOT in the hands of the direct caretakers. Each physician who treats a Gulf War veterans should have a copy of their one or per Clinic.

Kindly inform us if the Patient Care Staff have received any other specific gulf war health training in the last 24 months. Please identify this training material by title, subject and custodian of this material.

103d Congress, 2d Session - COMMITTEE PRINT - S. Prt. 103-97

IS MILITARY RESEARCH HAZARDOUS TO VETERANS' HEALTH?
LESSONS SPANNING HALF A CENTURY

A STAFF REPORT PREPARED FOR THE
COMMITTEE ON VETERANS' AFFAIRS

UNITED STATES SENATE
DECEMBER 8, 1994

JOHN D. ROCKEFELLER IV, West Virginia, Chairman

DENNIS DeCONCINI, Arizona	FRANK H. MURKOWSKI, Alaska
GEORGE J. MITCHELL, Maine	STROM THURMOND, South Carolina
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Jim Gottlieb, Chief Counsel/Staff Director
John H. Moseman, Minority Staff Director/Chief Counsel
Diana M. Zuckerman, Professional Staff Member
Patricia Olson, Congressional Science Fellow

FOREWORD

U.S. Senate,
Committee on Veterans' Affairs,
Washington, DC, December 8, 1994

During the last few years, the public has become aware of several examples where U.S. Government researchers intentionally exposed Americans to potentially dangerous substances without their knowledge or consent. The Senate Committee on Veterans' Affairs, which I have been privileged to chair from 1993-94, has conducted a comprehensive analysis of the extent to which veterans participated in such research while they were serving in the U.S. military. This resulted in two hearings, on May 6, 1994, and August 5, 1994.

This report, written by the majority staff of the Committee, is the result of that comprehensive investigation, and is intended to provide information for future deliberations by the Congress. The findings and conclusions contained in this report are those of the majority staff and do not necessarily reflect the views of the members of the Committee on Veterans' Affairs.

This report would not have been possible without the dedication and expertise of Dr. Patricia Olson, who, as a Congressional Science Fellow, worked tirelessly on this investigation and report, and the keen intelligence, energy, and commitment of Dr. Diana Zuckerman, who directed this effort.

John D. Rockefeller IV, Chairman

CONTENTS

I. Introduction

II. Background

- A. Codes, declarations, and laws governing human experimentation
- B. Mustard gas and lewisite

Mr. SHAYS. I thank the gentleman and we will just get some housekeeping taken care of.

Pursuant to House rules and committee rules I note for the record that the subcommittee requests that all witnesses appearing in this hearing in a nongovernment capacity provide a resume and a disclosure of Federal grants and contracts received and further ask that all testimony be submitted for the record and remarks by our colleagues be submitted for the record as well.

Without objection, so ordered.

I would also like to say that before calling our panel that this committee has had an excellent working relationship with the Department of Veterans' Affairs and we realize this is a partnership, so this is not a committee that is just standing in judgment of the VA. We also look at how Congress and the administration play a role in providing better health care for our veterans.

At this time, I am not sure if my mic is on all the time. Mine is not on at the time. I am not bringing the mic closer. I need the people in the back to get it better.

At this time, we will call Dr. Frances M. Murphy, Acting Director, Under Secretary for Policy and Management, Veterans' Health Administration, Department of Veterans' Affairs, accompanied by Dr. Jeannette Chirico-Post, Director of Veterans' Integrated Service Network I; and Mr. William Conte, Director, Edith Nourse Rogers Memorial VA Medical Center. I invite them all.

Remaine standing and I will swear you in.

[Witnesses sworn.]

Mr. SHAYS. Note for the record that the witnesses have responded in the affirmative.

Dr. Murphy, you have the testimony, but we are going to invite both of our guests as well to respond to questions. That is why you are all three under oath. I will note this committee swears every one under oath. The only one who has ever gotten away without being sworn in was Senator Byrd. All other Senators and Representatives have been willing to cooperate.

Thank you, Dr. Murphy.

STATEMENTS OF DR. FRANCES M. MURPHY, ACTING DEPUTY UNDER SECRETARY FOR HEALTH FOR POLICY AND MANAGEMENT, DEPARTMENT OF VETERANS' AFFAIRS; DR. JEANNETTE CHIRICO-POST, DIRECTOR OF VETERANS' INTEGRATED SERVICE NETWORK I; AND WILLIAM CONTE, DIRECTOR, EDITH NOURSE ROGERS MEMORIAL VA MEDICAL CENTER

Dr. MURPHY. Good morning. Mr. Chairman, Mr. Tierney, Mayor Scanlon, and honored guests. I appreciate the opportunity to appear before you today to discuss VA Health Care in the New Millennium. With me today are Dr. Post and Mr. Conte from the Edith Nourse Rogers Memorial VA Medical Center in Bedford, MA.

I would like to take the opportunity to compliment the Air Force ROTC and say it makes me proud to see our young people do so well.

The past decade has been characterized by dramatic change in the delivery of health care services in the United States. In the past 5 years, the VA health care system has also had a tremendous

transformation. VA has transformed itself from a disease-oriented, hospital-based health care system to an integrated system providing a continuum of accessible, coordinated, patient-centered, prevention-oriented care.

We have seen demonstrable improvements in our capacity to achieve consistent, reliable, accessible, satisfying and high-quality care. We also continue to face challenges of reducing medical errors in health care and meeting the needs of an aging population, of incorporating the explosive growth of scientific knowledge into daily practice and of incorporating expensive new medical and information technologies, and of realigning our infrastructure to more effectively support current health care needs.

Structurally, "New VA" is composed of 22 Veterans Integrated Service Networks [VISNs]. Each VISN forms a regional health care system that provides a continuum of health care to veterans who reside in a geographic area.

More than at any other time in our history, VA more closely mirrors—and in many cases exceeds—the best in private sector health care. Indeed, the structural transformation underpins a quality transformation. Significant organizational changes include: closing more than 52 percent of all hospital beds since July 1994; reducing inpatient admissions by 34 percent between 1994 and 1999; providing health to over 700,000 more veterans in 1999 than in 1994.

That is a 31 percent increase in the number of veterans cared for by the VA. Within the networks we consolidated managements and operation of 48 hospitals or clinics into 23 locally integrated health care systems since September 1995. Also we approved and brought 388 new community-based outpatient clinics into operation since 1995. We will establish more than 60 this year and that means that VA will have more than 1,200 sites of care across this Nation in bringing health care services into more veterans' communities.

Over that same period of time, we increased the rate of selected surgeries and procedures which are safely provided in the ambulatory setting to 92 percent of surgeries that are performed.

Especially notable in clinical achievements are reduced avoidable hospitalizations and lowered mortality, resulting in cost-savings through reductions in avoidable health care expenditures.

For example, the rates of pneumonia and influenza vaccinations provided to VA patients far exceed U.S. Public Health Service Healthy People 2000 goals and available benchmarks. Also, life-saving beta-blocker medications after heart attacks are provided at VA hospitals at rates that exceed all available benchmarks in the private sector. These two actions alone have saved, Mr. Chairman, an estimated 5,000 lives since instituted. That is an incredible accomplishment in quality health care for veterans.

Similar improvements have been seen in other areas of preventative health services such as screening for cervical and breast cancer and in the treatment of prevalent diseases such as diabetes and mental illnesses. Simultaneously, patient satisfaction has increased. In fact, VHA scored 79 on the externally conducted American Customer Satisfaction Index. This is significantly above the score obtained by the private sector health institutions who scored only 70 on that scale. Loyalty and Customer Service scores are even higher at 90 and 87, respectively.

Mr. Chairman, the VA New England Health Care System has shared in the accomplishments of the VA health system and in some instances has led the way. Network 1 also faces the same challenges that confront many other areas of the country.

I would like to take the opportunity briefly to discuss the accomplishments and challenges that are facing the New England Healthcare System (Network 1). Network 1 is an integrated and comprehensive health care system that delivers care to all six New England States, Maine, New Hampshire, Vermont, Massachusetts, Rhode Island and Connecticut.

Twenty-five community-based outpatient clinics are strategically located throughout New England and provide increased access to health care services for veterans. Network 1 has significant and long standing affiliations with some of the most prominent medical schools in the country. These include Boston University, Brown, Dartmouth, Harvard, Tufts, Yale, Universities of Connecticut, Massachusetts and Vermont Medical Schools and the University of New England. Funded research programs are another strong suit in Network 1 with the third highest research funding in VHA.

Over the past 5 years, from 1995 to 1999, VHA faced a very challenging budget situation. Our budget in real dollars decreased by 23 percent over that time period. However, I am pleased to tell you that with the \$1.7 billion increase that appropriated for VHA in 2000 and a \$1.3 billion increase that has been proposed in the Presidential budget for fiscal year 2001, we believe that we will be able to increase the access and decrease waiting times for veterans, further increasing the quality of care delivered by the Veterans Health Administration.

Network 1 has seen several changes in leadership during the past year. Mr. Fred Malphurs was appointed as the Interim Network Director, following the retirement of the former Network Director. Mr. Malphurs has been instrumental in setting a course that promotes teamwork, "open book management," and greater participation in network committees and strategic planning.

Recently, Dr. Jeannette Post was appointed as the Network Director after serving as the Acting Clinical Manager for 6 months. I am pleased to tell you that she brings to this position excellent management and clinical credentials and a passion for delivering quality health care services to the veterans of New England. We will provide effective leadership and expand the initiatives to provide quality, accessible health care services in an integrated delivery network.

I would like to turn the microphone over to Dr. Post at this point to let her tell you about the initiatives that will take place in Network 1 over the next several months.

Dr. Post.

[The prepared statement of Dr. Murphy follows:]

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(includes D & E)

**STATEMENT OF
FRANCES M. MURPHY, M. D., M. P. H.
ACTING DEPUTY UNDER SECRETARY FOR HEALTH FOR POLICY AND
MANAGEMENT
DEPARTMENT OF VETERANS AFFAIRS
BEFORE THE
SUBCOMMITTEE ON NATIONAL SECURITY, VETERANS AFFAIRS AND
INTERNATIONAL RELATIONS
COMMITTEE ON GOVERNMENT REFORM
U. S. HOUSE OF REPRESENTATIVES**

April 10, 2000

Mr. Chairman and members of the Committee,

I appreciate the opportunity to appear before you today to discuss "VA Health Care in the New Millennium." With me today are Dr. Jeannette Chirico-Post, Network Director, Network 1; and Mr. William Conte, Medical Center Director, Edith Nourse Rogers Memorial VA Medical Center, Bedford, Massachusetts.

VHA National Perspective

The past decade has been characterized by dramatic change in the delivery of health care services in the United States. In the past five years the VA health care system has also made a tremendous transformation. VA transformed itself from a disease-oriented, hospital-based health care system to an integrated system providing a continuum of accessible, coordinated, patient-centered and prevention-oriented care. We have seen demonstrable improvements in our capacity to achieve consistent reliable, accessible, satisfying, high-quality care. We continue to face challenges of reducing medical errors in health care; of meeting the needs of an aging population; of

incorporating the explosive growth of scientific knowledge into daily practice; of incorporating expensive new medical and information technologies; and of realigning our infrastructure to more effectively support current health care needs.

Structurally, the “New VHA” is composed of 22 Veterans Integrated Service Networks or “VISNs.” Each VISN forms a regional health care system that provides a continuum of health care services to veterans who reside in a geographical area rather than a collection of individual facilities providing episodic services to veterans who come to those facilities.

More than at any other time in our history, VA more closely mirrors – and in many cases exceeds – the best in private sector health care. Indeed, this structural transformation underpins a quality transformation. Significant organizational changes include:

- *Closing more than 52% of all hospital care beds since July 1994.*
- *Reducing inpatient admissions by 34% since FY 1994 and FY 1999.*
- *Reducing VHA's bed days of care per 1,000 patients by more than 68% nationally – from 3,523 to 1,136 between FY 1994 and FY 1999.*
- *Increasing annual ambulatory care visits from 24 to 37 million – a 52% increase – since 1995.*
- *Providing health care to over 700,000 more veterans in FY 1999 than in FY 1994 – a 31% increase.*
- *Within VISNs, consolidating management and operation of 48 hospitals and/or clinics into 23 locally integrated health care systems since September 1995.*
- *Approving and/or bringing 388 new Community Based Outpatient Clinics (CBOCs) into operation since 1995. VA now has more than 1,200 sites of care, bringing health services into more veterans' communities.*
- *And over this same period, increasing the rate of selected surgeries and procedures, which are safely provided in the ambulatory setting to 92%.*

Especially notable clinical achievements have reduced avoidable hospitalizations, lowered mortality, and resulted in cost-savings through reductions in avoidable health care expenditures. For example:

- *Rates of pneumonia and influenza vaccinations provided VA patients far exceed U.S. Public Health Service Healthy People 2000 goals and available benchmarks.*
- *Life-saving beta-blocker medications after heart attacks are provided at VA hospitals at rates that exceed all available benchmarks.*

Similar improvements have been seen in other areas of preventive health services such as screening for cervical and breast cancer and in the treatment of prevalent diseases such as diabetes and mental illness. Simultaneously, patient satisfaction has increased. In fact, VHA scored 79 on the externally conducted American Customer Satisfaction Index. This is significantly above the mean private sector health care score of 70. Loyalty and Customer Service scores were even higher at 90 and 87, respectively.

Mr. Chairman, the VA New England Health Care System (Network 1) has shared in the accomplishments of the VA health system and in some instances has lead the way. Network 1 also faces the same challenges that confront many other areas of the country.

Network Perspective

I will take the opportunity to discuss the accomplishments and challenges that are facing the VA New England Healthcare System (Network 1). Network 1 is an integrated and comprehensive health care delivery system that delivers care in six New England States: Maine, New Hampshire, Vermont, Massachusetts, Rhode Island and Connecticut. Twenty-five community based outpatient clinics are strategically located throughout New England and provide increased access to health care services for veterans. Network 1 has significant, longstanding affiliations with some of the most prominent medical

schools in this Country. These include Boston University, Brown, Dartmouth, Harvard, Tufts, Yale, Universities of Connecticut, Massachusetts and Vermont Medical Schools and the University of New England. Funded Research Programs is another strong suit of Network 1 with the third highest research funding in VHA.

Network 1 has seen several changes in leadership during the past year. Mr. Fred Malphurs was appointed as the Interim Network Director, following the retirement of the former Network Director. Mr. Malphurs has been instrumental in setting a course that promotes teamwork, "open book management," and greater participation in network committees and strategic planning. He has taken every opportunity to re-examine the business practices in the organization and to foster an organization that thinks "Network". Recently, Dr. Jeannette Chirico-Post was appointed as the Network Director, after serving as the Acting Network Clinical Manager for six months. She brings to the position excellent management and clinical credentials and a passion for delivering quality health care services to the veterans of New England. She will provide effective leadership and expand the initiatives to provide quality, accessible health care services in an integrated delivery network.

In the spirit of the One VA initiative, Network 1 is working with the Veterans Benefits Administration (VBA) to explore co-location of VBA services on-site at the VA Connecticut Healthcare System and the Providence VA Medical Center. Recently, VHA and VBA in New England collaborated on a task force to streamline the process for compensation and pension examinations. The recommendations are being published in Network 1's March issue of "Veterans' Healthy Living," which will be mailed to over 200,000 veterans in New England.

Seeing the need for a comprehensive planning document to guide the Network, a draft strategic plan was created and disseminated in January 2000. This document is the beginning of the Network planning cycle and is designed to elicit feedback from stakeholders as to the direction the Network will take over the next several years.

Network 1 is committed to transforming its health care delivery system to respond to the challenges of the revolutions in health care and new technologies. The speed of change in the quantity, quality, and types of health care programs is rapidly increasing. For example, the new emphasis on community-based programs will result in an expansion of programs such as community-based outpatient clinics and home-based primary care. The Network's goal is to increase the number of veteran users by 5% and decrease the cost of care by 5%. A major Network 1 initiative has been the development of an integrated health care system based on primary/ambulatory care. Implementing the primary care model has resulted in improved continuity, improved satisfaction and an increase in the number of patients served. The transition of some resources from hospital-based to CBOCs and other community-based programs have facilitated veteran's access to care. The Network opened a new CBOC in Southern Maine on March 17, 2000. We expect the following CBOCs to be opened in 2000:

<i>Massachusetts:</i>	<i>Dorchester, Fitchburg, Gloucester, Martha's Vineyard, Nantucket, Plymouth, Quincy and Turners Falls</i>
<i>New Hampshire:</i>	<i>Conway, Wolfboro</i>
<i>Connecticut:</i>	<i>Danbury</i>
<i>Rhode Island:</i>	<i>Newport</i>
<i>Vermont:</i>	<i>St. Johnsbury</i>

Another strategic goal of Network 1 is to integrate health services by fully implementing Care Line management. Implementing Care Lines will result in a higher degree of coordinated care in Primary Care, Mental Health and Behavioral Sciences, Spinal Cord Injury, Specialty and Acute Care, and Geriatrics and Extended Care. Another major initiative is the consolidation of Boston and West Roxbury facilities. Acute inpatient services will remain on the West Roxbury campus and ambulatory care services will be enhanced at the Boston site. The consolidation will reduce redundant services and eliminate administrative duplication.

Numerous alliances that will expand access are being entered into through sharing agreements such as with TRICARE and the Department of Defense (DoD). New technologies such as telemedicine and teleradiology are also expanding access to care for patients. Accessibility of patient information is greatly enhanced for providers through Network 1's information system, such as the electronic patient record and WebTop. Network 1's Internet/Intranet sites also facilitate access to information. Further investments in information systems technologies will facilitate expansion of services into rural areas.

Network 1 is committed to providing quality health care and services to the veterans it serves across New England. The goal is to provide the right care, at the right time and at the right level required to safely and compassionately meet the unique needs of each veteran.

This process integrates and emphasizes customer feedback to assure that value is added for patients and other stakeholders. Since the inception of standardized customer service feedback surveys, Network 1 has consistently been the leader in Ambulatory Care Customer Satisfaction. Feedback from patients is one of the most significant measures of quality. Network 1 is currently number "ONE" in the country in the percentage of ambulatory patients rating overall quality of care as Very Good or Excellent. In addition, for FY 1998 and FY 1999, Network 1 was the only Network to perform at least two standard deviations better than the national VHA average in each of the categories of customer service and is quickly approaching the standard of excellence reported by the Picker Institute (Access, Preferences, Patient Education; Emotional Support; Coordination of Visits; Overall Coordination; Continuity of Care, Courtesy, Pharmacy and Specialty Care).

With regards to quality of care measures, Network 1 has demonstrated progressive and consistent improvement in the areas of disease prevention, the management of chronic disease, and use of nationally accepted clinical practice guidelines. Although they have not yet reached their performance goals, they have demonstrated a substantial rate of improvement in performance overall in

national measures. They continue to perform exceptionally in the area of palliative care.

Network 1 has a strong commitment to continuous quality improvement utilizing an integrated approach to standardize to best practices throughout the Network. There has been great success in significantly enhancing access to care by decreasing waits and delays for clinic appointments as a part of a VHA collaborative project with the Institute for Healthcare Improvement to reduce waits and delays. We are proud of Network 1's accomplishments and will aggressively spread lessons learned to include clinics Network-wide.

Other areas of emphasis to add value to veteran's health care services include: pain management, case management, clinical practice guidelines, utilization management, telemedicine and telephone advice programs.

Network 1 was the first Network to obtain JCAHO Network Accreditation with Commendation. It was recognized for meritorious achievement as a finalist for the Kizer Quality Achievement Recognition Grant last year and is committed to continuing to challenge itself through these and other external assessments. Network 1 is the main site for the Quality Scholars Fellowship Program and one of four National Patient Safety Centers of Inquiry in VHA.

With quality, cost, and marketplace challenges facing Network 1, communications have become even more critical to assure a high performance organization. Network 1 has established a communication system that is customer-focused and supports the Network's mission and goals. Network 1 has embarked on a new mission to communicate more often and in more detail with veterans, employees, affiliates, congressional offices, local unions and other stakeholders. A Communications Council has been established with representatives from Network staff, Care Line managers, patient education representatives, and veterans.

A number of communication tools have been developed that are responsive to the needs of patients, employees, and stakeholders and enhance understanding of Network initiatives. The monthly electronic newsletter, "News at a Glance" is distributed to approximately 9,100 recipients including employees,

affiliates and congressional offices to provide up-to-date information on new initiatives and events occurring throughout the Network. The first issue of a quarterly health and wellness newsletter entitled, "Veterans' Health Living" was just distributed to 200,000 user and non-user veterans in New England. This newsletter provides patient education, health promotion, and highlights Network initiatives. A quarterly published employee newsletter will be published in April to include more in-depth articles on strategic initiatives, awards, and achievements from the six New England States.

The communication publications are also made available on the Intranet/Internet web sites to facilitate access to information for patients, employees, and other stakeholders. In addition, a section entitled "Frequently Asked Questions" for the Director was added to the web site as another means of providing consistent, coordinated information. All of these publications have built-in customer surveys to ensure there is a two-way communication system process.

The Executive Leadership Council, the policy-making body of the Network, has been expanded to include a broader representation of the stakeholder interests in the Network. Over the last four months, this more inclusive representation of local labor unions, clinical managers and employees, has proven invaluable to the deliberation and implementation of strategic direction for the Network.

Challenges facing Network 1

One of the greatest challenges facing Network 1 is the need to come together as one Network instead of its current parochial orientation of nine individual medical centers. Recognizing the reality of the parochial interests of the six New England states with individual congressional delegations, veteran service organizations, local unions and individual medical school affiliations, Network 1 needs to move from a hospital-centered system to a Network centered system which provides health care services along the entire health care continuum. The Network must re-engineer its business processes and implement

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clinical practice guidelines to ensure there is a single, consistent standard of quality health care regardless of the geographic location where the care is delivered.

Network 1 will further implement Service/Care Lines as it evolves to a more clinically integrated delivery system. Service/Care Lines are intended to enhance the provision of uniform, high quality care/services throughout the Network by reducing variations in care and standardizing availability and coordination of services. The Service/Care Line is a multidisciplinary team united by function and driven by outcome goals for the services it provides. This allows for improved management of patients along a seamless continuum of care.

Seven Network Clinical Service Lines are in various stages of development and implementation including Laboratory, Primary Care, Mental Health and Behavioral Sciences, Acute and Specialty Care, Spinal Cord, Geriatrics and Long-Term Care and Prosthetics. Each Care/Service Line has an identified leader who, in the future, will manage resources to achieve measurable outcomes of improvement. An eighth consolidated program, Pharmacy, is currently being planned for rapid deployment.

The Geriatrics & Long- Term Care Line is currently being implemented. This care line will play an integral role in implementation of the provisions in the Millennium Bill. There will be a shift of emphasis by promoting increased care at home and within the community where clinically appropriate. Increased use of technology such as telemedicine will assist in this transition. VA nursing home care will serve as the most intense level of extended care and will focus on subacute and restorative care with the goals of maintaining function and/or providing chronic care at the least intense level.

Network 1 has initiated a series of meetings to partner with the Commandants of the State Veterans Homes in New England. These meetings have highlighted our mutual interest in serving veterans and to date, have accomplished the following initiatives: sharing prime vendor contracts; sharing agreements for purchasing medical supplies; priority access to excess VA equipment; and lease agreements for unused VA space.

The VERA resource allocation system was developed in response to a congressional mandate that required VHA to allocate funds in an equitable manner. This allocation system was developed to match resources with patient needs across the country. This created shifts in resource allocation, phased in over a three-year period. Although, this Network received reductions in resource allocations in the first two years under VERA. In FY 2000, Network 1 received a 5.5% increase or \$43 million dollars over its FY 1999 allocation – which equates to a 6.0% increase or a Network average price of \$4,853. Assuming VA receives the President's requested funding In FY 2001 for Veterans Medical Care, it is projected that Network 1 share of VERA funding would be 2.9% or \$24 million dollars above FY2000.

Network 1 has a cost per unique patient that is approximately \$400 greater than the national mean, and has staffing ratios that are some of the highest in the country. Although significant strides have been made to reduce overall cost per patient, additional efforts to gain efficiencies through reorganization of health care delivery systems are required. These efforts will improve the Network's ability to deliver high quality care and serve more patients at a reduced cost in the future.

It is widely recognized that access to information will be the cornerstone of the "New VHA". The successful implementation of information technology will have a direct impact on Network 1's success in delivering integrated health care services throughout New England. VHA has made the development of a computerized patient record a major long-term goal. In the emerging clinical information environment, all information relevant to treating a patient must be available in such a way that it is secure yet accessible to health care providers clinical and management decision-makers, educators, and researchers.

CPRS, the Computerized Patient Record System, enables clinicians, nurses, clerks, and others to enter, review, and continuously update all information connected with a patient. CPRS, which is in use at all nine VA medical centers in Network 1, organizes and presents all relevant data on a patient in a way that directly supports clinical decision making and patient care.

The ultimate goal of CPRS is to create an integrated patient record system that gives physicians both efficient ordering and documentation capabilities as well as enough information to make better decisions regarding orders and treatment. This system provides a safer environment for our patients and staff.

Network 1 is actively implementing the VistA imaging system, which captures clinical images and scanned documents and makes them part of the patient's electronic medical record. Images and text files are provided in an integrated manner which facilitates the clinician's task of correlating the data and making patient care decisions in a timely and accurate way. The system aids communication and consultation among physicians -- whether in the same department, in different services, or at different sites.

To allow clinical access to information throughout New England, Network 1 is implementing a web browser technology called WebTop. This state-of-the-art information technology allows the clinical staff to access a single database and retrieve electronic medical record information on any patient treated at other VA medical centers in VISN 1.

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Medical Center Perspective

Since this hearing today is being held in Peabody, Massachusetts, I will provide you with information on a few of the many successful local initiatives. VHA and Network 1 appreciate the support and encouragement of the New England Congressional Delegation in the opening of new Community Based Outpatient Clinics. Congressional support was instrumental in the success of the clinics in Lynn and Haverhill, and to the proposed clinic for Gloucester. The clinic in Haverhill is located within Hale Hospital, a facility-owned and operated by the City of Haverhill, creating a mutually beneficial partnership with the community. The clinic in Lynn is located in a private sector medical building. Both the Lynn and Haverhill clinics provide primary care services and have expanded to include mental health counseling.

The Edith Nourse Rogers Memorial Veterans Hospital, in Bedford, operates an Alzheimer's care program that is nationally known for the

comprehensive quality care provided. It is comprised of an Outpatient Program, an Adult Day Care Center, and an Inpatient Program. The Alzheimer's care program is fully integrated with the Geriatric Research Education & Clinical Center (GRECC). The Bedford GRECC program is a unique program in that it is fully integrated with clinical care; a full partner with its academic affiliate (Boston University); and designated by VHA Headquarters as a National Center to facilitate cooperative efforts between the VA, private sector health care organizations and pharmaceutical companies.

To enhance the continuum of health care services provided to veterans, the Bedford VA Medical Center has embarked on two innovative projects utilizing the Enhanced Use sharing authority. The first proposal is to establish a cooperative venture with a private sector organization for construction and operation of an Assisted Living Center at the Bedford VA Medical Center with an emphasis on patients with Alzheimer's. In return for the ability to utilize VA property, the private sector organization will provide bed space for VA patients at no charge. This proposal is expected to be approved and construction started in 2001. The second proposal would establish a cooperative venture with the New England Shelter for Homeless Veterans (NESHV), a non-profit organization, for construction and operation of 40 units of Single Residency Housing at Bedford. In return for the ability to utilize VA property the NESHV will provide several units for VA patients at no charge. This proposal is expected to be approved and construction started in the near future.

Another example of a VA-private sector partnership is in the area of health care services to homeless veterans. A private sector homeless services provider, Ms Leslie Lightfoot, has received a VA Grant to obtain, equip and operate a health care van in the greater Worcester, MA area. This program will provide the van at scheduled, designated locations to perform basic health screenings and follow-up. The Bedford VA Medical Center will provide expertise in the planning phases of this project and will provide equipment, supplies and personnel to support this important homeless outreach effort which is expected to be operational by this fall.

Conclusion

Thank you for the opportunity to discuss the achievements and challenges of VHA at the National, Network and local level. This concludes my opening statement and I and my colleagues would be pleased to answer any questions you or the members of the committee may have.

Dr. POST. Thank you for the opportunity to discuss the accomplishments and challenges that are facing the VA New England health care system. Network 1 is an integrated and comprehensive health care delivery system that delivers care in the six New England States. Twenty-five community-based outpatient clinics are strategically located throughout New England and provide increased access to health care services for veterans.

Network has a significant and longstanding affiliation with nine of the most prominent medical schools in this country. We are the third highest research funding in VHA. Network 1 is committed to provide quality health care services to the veterans throughout New England. The goal is to provide the right care at the right time and at the right level required to safely and compassionately meet the unique needs of each veteran.

A major Network 1 initiative has been the development of this integrated health care system based in primary care. This primary care model has resulted in improved continuity, improved satisfaction and an increase in the number of patients served.

The Network opened a new CBOC in southern Maine on March 17 and we expect to open 12 new CBOCs this year. Feedback from patients is one of the most significant measures of quality. We are currently No. 1 in the country in overall quality of care as rated by ambulatory care patients.

Network 1 was the first network to obtain the joint commission of accreditation, network accreditation with commendation. It was recognized for meritorious achievement as a finalist for the kinds of quality achievement recognition grant last year.

Network 1 has embarked on a new mission to communicate more often and in more detail with veterans, employees, affiliates, congressional offices, local unions and other stakeholders. A number of communication tools have been developed that are responsive to the needs of patients, employees and stakeholders and enhance the understanding of network initiatives.

All nine VA Medical Centers are utilizing the computerized patient medical record. We have implemented a state-of-the-art information technology called Webtop which will allow a clinician anywhere in New England to access the electronic medical record for any enrolled patient. Both of these systems will foster communication and consultation among physicians throughout New England.

One of the greatest challenges facing Network 1 is the need to come together as one network instead of its current, parochial orientation of nine individual medical centers. Network needs to move from a hospital-centered system to a Network patient centered system which provides health care services along the entire health care continuum. The Network must re-engineer its business processes and implement clinical practice guidelines to ensure there is a single, consistent standard of quality health care regardless of geographic location of care and delivery.

Another strategic goal of Network 1 is to integrate health services by fully implementing Care Line management. Care Lines are intended to enhance the provision of uniform, high quality services throughout the network by reducing variations in care and standardizing availability and coordination of services. This allows for

improved management of patients along a seamless continuum of care.

Another major initiative is the consolidation of the local Boston facilities, Jamaica Plain, West Roxbury and Brockton. The consolidation will reduce duplicate clinical services and business processes. The Bureau of Resource Allocation System was developed to match resources with patient needs across the country. Although the network received reductions in resource allocations in the first 2 years, in fiscal year 2000 Network 1 received a 5½ percent increase or \$43 million more than the prior year. It is projected that our next year's funding will be a 2.9 percent increase equated to \$24 million.

Network 1 has a cost per unique patient that is approximately \$400 greater than the national need and has staffing ratios that are some of the highest in the country. We have made strides to reduce overall cost per patient, however, we need to gain additional efficiencies through reorganization of health care delivery systems. These efforts will improve the network's ability to deliver high quality care and serve more patients at a reduced cost in the future.

Thank you for the opportunity to discuss the achievements of Network 1.

Mr. CONTE. For those who do not know the scope of the Bedford Hospital, it is basically a long term care facility psychiatric care with rehab focus, a large Alzheimer's component and a primary care clinic around the eastern Massachusetts area and a large research component.

Since this hearing today is being held in Peabody, MA, I will provide you with information of a few of the many successful local initiatives. VHA Network 1 appreciates the support and encouragement of the New England Congressional Delegation in the opening of new community based outpatient clinics.

Congressional support was instrumental in the success of the clinics in Lynn and Haverhill, and to the proposed clinic for Gloucester. The clinic in Haverhill is located with the Hale Hospital, a facility owned and operated by the city of Haverhill, creating a mutually beneficial partnership with the community. The clinic in Lynn is located in a private sector medical building. Both the Lynn and Haverhill clinics provide primary care services and have expanded recently to include mental health counseling.

The Edith Nourse Rogers Memorial Veterans Administration Hospital in Bedford operates an Alzheimer's care program that is nationally known for its comprehensive quality care. It is comprised of an Outpatient Program, an Adult Day Care Center and an Inpatient Program.

The Alzheimer's care program is fully integrated with the Geriatric Research Education and Clinical Center known as a GRECC in the VA facility. The Bedford GRECC program is a unique program in that it is fully integrated with clinical care, a full partner with its academic affiliate, Boston University, and designated by VHA Headquarters as a National Center to facilitate cooperative efforts between the VA, private sector health care organizations and pharmaceutical companies.

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In return for the ability to utilize VA property, the private sector organization will provide bed space for VA patients at no charge. This proposal is expected to be approved and construction started in 2001. The second proposal would establish a cooperative venture with the New England Shelter for Homeless Veterans, a nonprofit organization for construction and operation of 40 units of Single Residency Housing at Bedford. In return for the ability to utilize VA property, the New England Shelter will lease the building and this will help us offset some of our operational costs. This is a change in the testimony. This proposal is expected to be approved and construction started in the near future.

Another example of a VA-private sector partnership is in the area of health care services to homeless veterans. A private sector homeless services provider, Ms. Leslie Lightfoot, has received a VA Grant to obtain, equip and operate a health care van in the greater Worcester, MA area. This program will provide the van at scheduled, designated locations to perform basic health screenings and followup.

The Bedford VA Medical Center will provide expertise in the planning phases of this project and will provide equipment, supplies and personnel to support this important homeless outreach effort which is expected to be operational by this fall.

Thank you.

Mr. SHAYS. At this, Mr. Tierney, I invite you ask any questions you would like.

Mr. TIERNEY. Thank you very much, Mr. Chairman, I thank the members of the panel for their testimony.

I want to ask Mr. Conte a question first, but I think I would be remiss if I did not share with the folks that are here, as well as with the chairman, just the wonderful work that the folks at the VA Hospital in Bedford have done and the cooperation that they have given my office and the veterans' councils and agents throughout the district.

We have had a number of health fairs that probably could not have happened without Mr. Conte and his staffs volunteering considerable amounts of their time on several days in this past couple of years in Haverhill, in Lynn and out in Gloucester where people gave their time to run the tests, to sign people up to make sure that we had appreciation for the number of veterans who would, in fact, utilize those services.

And so I want to thank you publicly and your staff through you for the cooperation that you have had. And it went beyond that. Once the CBOCs were actually cited first on the North Shore and then in Haverhill. The staff worked with local veterans' councils and gave them a voice in where they would be located and how they would be established and how they would be staffed and that continues to go on, so we are very, very appreciative of that.

Last, let me just say we gave you a major headache at one point in time when we put out a veterans' newsletter that indicated that there was a prescription drug benefit to which veterans were entitled and I think the next day you had over 500 phone calls rushing into the clinics and your office was good natured and gracious about building those and making sure that the veterans, in fact, got the benefit of those services so on behalf of veterans I would thank you for making sure that they were well served with the right disposition and attitude when that increase of calls came in.

As you know, Mr. Conte, I am very much a proponent of the community-based outpatient clinics. Can you tell us roughly what resources these clinics that are in this district have had and how many physicians and nurses they have and what type of care they are generally provided?

Mr. CONTE. Yes. I will start with Lynn. Lynn was originally staffed with the positions of a physician and a nurse practitioner and administrative support and that would be roughly in the area of about \$350,000 worth of personal services and then in the Lynn area we contracted with a medical building there and I believe the lease was in probably the \$30,000 range, so we are looking at about \$400,000 roughly that goes into that clinic when it started a year and a half ago.

We have increased services. At this point we have mental health practitioners going up there now, so I would say we are well up over \$500,000, according to that clinic. That does not count all the new patients or the new prescription drugs and all the services we provide back at the Bedford facility. Haverhill was brought up the same way.

Both of these clinics were brought up as a startup initiative, let it grow and let us meet the demand. Haverhill is very similar in terms of its original start. It was a nurse practitioner, physician and administrative support, again in the \$300,000 to \$500,000 range at this point in time.

Mental health services are expanding in both those areas as we speak.

Mr. TIERNEY. Does the entire budget for those facilities come from the Bedford facility?

Mr. CONTE. In the past, yes, that has been true and the issue was that if we did get an outpatient clinic we would generate those dollars within the facility and the VA facility at Bedford, we have been very dynamic in rearranging, reprogramming dollars.

We have done a lot of sharing with other facilities. We have done a lot of consolidations for things like administrative services. For example, a good example, we used to have a large kitchen staff, now we do cook/chill which is basically cooked in West Roxbury, the food is prepared there, it is brought to the veterans facility and that saves us a lot of dollars and that provided the dollars to expand to those clinics.

The Haverhill staff are part of the Bedford facility and so are the Lynn staff, so is the Winchendon staff. There is another group out in Winchendon that people do not realize has been there for many years. Also the VCC in the Lowell area, Veterans' Community Care Center.

Mr. TIERNEY. And despite, has the Bedford facility been able to maintain its patient case load, the waiting time has been about the same and not increased?

Mr. CONTE. Two questions. The waiting time, 5 years ago, we have a member of the GPRA, Government Performance Review Act. We are a pilot site. We establish times that were in the range of 7 days and less than 30 minutes to be seen in a primary care clinic. Over those 5 year periods, I do not think we have exceeded those times four or five times. We have a strong QA program that monitors that, so we have been working with that for many years, so yes, we have been able to maintain our times by shifting staff in the ambulatory care.

The other issue is that the dollars that we have taken from programs have enhanced that ability to expand those clinics. We have expanded some clinics and have been able to maintain those times, yes.

Mr. TIERNEY. One of the issues I expect me hear about something today, but I heard about it quite frequently in our offices is transportation. I understand there is shuttle service to the Bedford facility, but I would like for you to take a moment, if you would to describe how often the shuttle runs and what is entailed in participating in that transportation.

Mr. CONTE. Difficult question. They change quite a bit. There is shuttle that runs from the Worcester clinic, excuse me, from the Lynn clinic to Bedford and back, I believe four times a day, a morning run and the afternoon run. There is also a shuttle that runs to the Haverhill clinic back to Bedford and then there is part of a consolidated transportation network that is working out of Boston that the VISN initiative startup was a VISN initiative about a year and a half ago when they were working the transportation network.

We, ourselves, at the Bedford facility decided to run this shuttle to try to get people back to the Bedford facility when they need that kind of care and I think it has been reasonably successful. As the clinic expands, there may be need for more transportation. Obviously, you identified that earlier.

Mr. TIERNEY. How is the staff of these programs being paid? Are they being paid by the clinics themselves or?

Mr. CONTE. Out of our operating dollars at the veterans facility, certainly.

Mr. TIERNEY. Are there any other plans for that network transportation concern in the future?

Mr. CONTE. At the VISN letter there is a Boston consolidated transportation network and actually there was a contract let out about a year and a half ago and there was an evaluation period. We are going through that right now, for the private sector vendor who was coordinating that transportation network in the Boston area. Lynn and Haverhill are not included the initial startup of that, so we ran the vans ourselves, but we have to look at that, yes.

Mr. TIERNEY. With the indulgence of the chair I would like to continue. I am beyond my time for a couple of seconds.

Can you describe how someone who wanted to go to the clinic in Haverhill would actually get to say Jamaica Plain or Bedford or West Roxbury if they needed to get there, how that works?

Mr. CONTE. I believe there is a van that is going down to Jamaica Plain, but it is not as regular, I believe, as the one we have running back from Bedford, but you could take two routes, obviously, public transportation being another option, but you could take a van from the Lynn clinic to Bedford and then from Bedford into Jamaica Plain which makes it a little difficult sometimes and I believe we are starting an initiative to run a van from those clinics because they have gotten to the point where you have enough demand. In the past there has not been that demand.

Mr. TIERNEY. Is the demand for the service of the clinics actually helping our budget here locally, the way the current funding situation is going?

Mr. CONTE. I would think so. Our numbers alone have gone from about 9,700 veterans to over 11,000 and we have been trying to put a finger on that, if they were coming to Bedford and now to Lynn or if they were new at Lynn and I would strongly support the idea that more people are coming to the Lynn and Haverhill clinics because of access and therefore we are earning more dollars under this VERA model, yes.

Mr. TIERNEY. Now a lot of veterans have asked questions about the plans to implement the new millennium bill, maybe you could help us first by telling us a little bit about the requirements of the bill or Dr. Murphy or Dr. Post or whoever, just give a brief outline about the millennium bill and then maybe I think somebody was a little perplexed about the lack of funding, a vital functioning of that particular bill and all that it calls for and I would like for you to tell us what your approach is going to be in dealing with that.

Dr. MURPHY. I will start and then I will turn it over to Dr. Post. The millennium bill is a rather complex piece of legislation. The millennium bill provides for a continuum of long-term care. In fact, it provides long-term care to veterans who are greater than 70 percent service connected and allows VA to provide that care on a more consistent basis.

It also gives us the ability to provide noninstitutional long-term care by allowing us to set up pilots for assisted living and to do more home-based, long-term health care. It also changes some of the provisions for the State homes.

As you can imagine, the implementation of this legislation requires many policy decisions and publication of regulations. We are well into that process and expect to be able to move forward relatively quickly. In fact, Dr. Post spent last week down in Leesburg, VA leading one of the seven subcommittees working on the implementation plan for that bill. It is a complex piece of legislation, but it does give veterans more access to the long-term care that they are going to need in the future.

Were there specific aspects of the bill?

Mr. TIERNEY. I was interested in the funding of it which I think is problematically probably more on our level than yours, but I am curious to know what your approach is going to be.

Dr. MURPHY. We did put specific funding into the 2001 budget that will allow us to fully fund the long term care piece of that legislation.

In addition, the legislation set out VA authority to charge copayments for some long-term care and so part of what will pay for that

is some of the co-payments that we will collect from veterans who use the long-term care.

Mr. TIERNEY. Does that also include—I was concerned that as that bill was coming through Congress with the prescription drug aspect of that. I was very concerned at the beginning, but there is now an allowance for an increase in the co-pay on that. Do you anticipate that that is going to a severe increase, moderate increase, no increase?

Dr. MURPHY. We do not believe that there will be a very large increase in the pharmacy co-payments. The problem was that the level of co-payment the VA was charging was not even paying for the administrative costs of sending out the bills for the copayments. I think the copayments are likely to be under \$10 and probably closer to \$5 per monthly medication refill.

Mr. TIERNEY. Thank you.

Dr. POST. I just wanted to add to the comments that Dr. Murphy just gave you about the implementation of the millennium bill. If you believe that all health care should be local I think VA has moved in the right direction by establishing an increasing number of access points or CBOCs and in our network alone with the additional 10 to 12 that will happen in this year, that will be a plus.

The millennium bill affords us the opportunity to make all long term care local and that includes not only the institutional care, but the noninstitutional care and we in New England have already started to move to enhance that access, our relationships with the State Veteran Homes, the further development of the geriatric and long-term care on that. We have additional development of 24 hour day, 7 day a week contact with us from the emergency room.

Mr. TIERNEY. Can you tell me how that will work? Are you going to reduce bed space now and bring it more out to the community and more outpatient based. What about the long term care inpatient demand? When that increases in the future, will we have what we need to address that?

Dr. POST. I think that is part of the process for us. Part of the process is to decide where is the right level for the patient to be maintained for the longest period of time for the patient to maintain his functional independence.

Mr. Conte talked about our Alzheimer's unit at the Bedford VA which maintains the patient from an ambulatory care through a day care and then up through institutional care. I think that over time the issue for us is to have the right size and I do not know if I can predict the numbers that are there for right now.

Mr. TIERNEY. Are you in the process of doing any sort of survey or determining what the likely demand for in-patient care is going to be for baby boomers?

Dr. POST. I think that is part of our geriatric/long term care line to make an assessment of where we should be and then to address, as Dr. Murphy has said, through the millennium bill, the additional placement of those patients that are 70 percent or greater.

Mr. TIERNEY. Thank you. Mr. Chairman, why do not I let you have a few questions.

Mr. SHAYS. Thank you. I am going to ask these questions as if I were in Washington and not be concerned that I am asking them

in Massachusetts, but the purpose is to understand the challenges and to give you an opportunity to respond to it.

In Connecticut, we felt we did our duty by consolidating Newington and West Haven and making it one system which is referred to as the Connecticut Health Care System. You have a facility in Vermont. You have a facility in New Hampshire. You have a facility—I am talking major facilities, not community-based health care clinics, a major facility in Rhode Island as well. And you have four facilities in Massachusetts, I believe, and now you have consolidated two and I just want to sense, is there going to be eventually one Massachusetts Health Care System coordinating the major hospitals?

Dr. POST. The process to look at the delivery of health care in Massachusetts was thoroughly reviewed. That review process began some 2 to 3 years ago as we came to be an integrated delivery system. And actually, Mr. Conte and I were on one of the first groups to look at what we should do in the network for those two locations, 5 miles apart, Jamaica Plain and West Roxbury. West Roxbury had already been joined with the Brockton VA I think some 10 years prior to—

Mr. SHAYS. How many major facilities are we talking about in community based health care clinics?

Dr. POST. Bedford, JP, Jamaica Plain, West Roxbury and Brockton.

Mr. SHAYS. Five facilities. I am sorry, four.

Dr. POST. Four facilities.

Mr. SHAYS. Right, consolidated into how many?

Dr. POST. No, Bedford is still unique. The Jamaica Plain, West Roxbury and Brockton have been in the process of consolidating and integrating into a single health care system.

Mr. SHAYS. And it will have one so then you will have two budgets.

Dr. POST. Right.

Mr. SHAYS. And the savings from that, it seems to me can then be poured into—it does not go back down to Washington, it stays up in District 1?

Dr. POST. Correct, in VISN 1.

Mr. SHAYS. When will that consolidation be concluded?

Dr. POST. It is projected to be finished within the next 3 to 4 years.

Mr. SHAYS. So right now we have five community based health care clinics in Connecticut. Is there any plan to open any others, do you know?

Did I ask the wrong question? [Laughter.]

Dr. POST. And I did not even answer yet.

Mr. SHAYS. Is that your final answer? I would just be interested in knowing how the transcriber records that event. [Laughter.]

I saw some veterans actually dive for—as they are trained.

Yes?

Dr. POST. If I may answer the question, as we as a network look at where care is delivered and I said it before and I will repeat my phrase of health care is local, so there are additional CBOCs planned for Massachusetts as well as Connecticut.

Mr. SHAYS. Will any of these go through—you have 5 in Connecticut, 6 in Maine, given the size of the State, 2 in Vermont, 10 in Massachusetts, 2 in New Hampshire and none in Rhode Island, community based health care clinics. Do I have old information?

Dr. POST. No, that is correct.

Mr. SHAYS. Now do you have plans to increase the number in Connecticut, in Massachusetts? Are there any specific ones that you can mention?

Dr. POST. I would be happy to mention some of them. We actually have just submitted, I think it is four or five that have gone into headquarters for the technical review that is required and I will check on the site of the Connecticut one. I just cannot remember. I think it is Danbury.

Mr. SHAYS. I think you are right.

Dr. POST. OK, and in Massachusetts, it is the Gloucester clinic, it is Quincy, two sites, Turners Falls in the western part of the State of Massachusetts and additional ones in Massachusetts to be considered. And in Rhode Island, there is one in Newport, Martha's Vineyard in Massachusetts as well is being considered.

Mr. SHAYS. Massachusetts now has three community based health care clinics?

Dr. POST. That is correct.

Mr. TIERNEY. This is a powerful man.

[Applause.]

Mr. TIERNEY. These clinics have enabled you, it seems to me, to provide a better service for those particular needs at a reduced cost, is that correct?

Dr. POST. That is correct and as I mentioned in my opening testimony that as an integrated delivery system, as we move toward an ambulatory care or primary care service line, we will develop as a network a standard of care across the network that is to the best practice so that the care that is rendered in Lynn and Haverhill is the same that is rendered in Newington and West Haven clinics in Connecticut. We can, as an integrated delivery system, then grow in terms of meeting the needs of our patients.

As Mr. Conte said, the majority of care that is delivered in our CBOCs is primary care. Good primary care can meet 80 to 85 percent of the needs of our veteran population. Following that, the specialty services, the mental health services. As we know the population that we are managing, then we need to provide the additional support for both the mental health and the specialty clinics.

Mr. TIERNEY. Now the way the system works, as you service more veterans, you get more resources provided, correct?

Dr. POST. Correct.

Mr. TIERNEY. So it is based on the number of veterans served.

Dr. MURPHY. Correct.

Mr. TIERNEY. And it strikes me that by expanding community-based health care clinics you are reaching more veterans as they get older who need this service who do not have to go into a larger facility with the bureaucracy sometimes associated with the larger facility. It is more personal and so on. I think the next hearing that I want to know is why does one Member of Congress get three in a State with only 10 Members, but that is for another hearing.

Mr. SHAYS. Let me just ask you another question. One of the tragedies of our failure to properly—is there someone who is kicking the mic that we do not know about? It is a shocking sound.

Let us give it a try. Our failure to properly protect our blood supply resulted in the HIV virus working—that pathogen working into our blood supply, but one of the silent killers was hepatitis C and in the course of our hearings we learned about hepatitis C a number of years ago.

My sense is that the VA has done a better job than almost any other health care network in terms of dealing with hepatitis C and I would just like to know if, Dr. Murphy, you could give us a sense of what is happening there?

Dr. MURPHY. I would be happy to. Thank you for the compliment on our hepatitis C program. I think VA has been very proactive on this issue. And one of the reasons for that is that VA or veterans have a higher rate of hepatitis C than the general population. The population in the United States has a rate of about 1.8 percent of hepatitis C and veterans at least by our estimates from a 1-day screening program have a rate of about 6.6 percent, so it is significantly elevated in the veteran population.

In our drug treatment programs it can be up to 40 percent of the IV drug abusers being treated, so it is a very important problem for veteran.

Hepatitis C can cause chronic liver disease, including cirrhosis and liver failure and sometimes result 20 or 30 years down the line in liver cancers. So it is important to identify the infection by screening veterans and the risk factors include exposure to infected blood products from transfusions or from IV drug abuse and also other blood exposures.

If you go into a VA medical center the physicians and health care providers will ask you about risk factors for hepatitis C and offer you a blood test that can rule out hepatitis C. Prior to 1992 there was not a blood test that could be done and so individuals who received blood transfusions prior to that date may have received infected blood products.

We have screened several hundred thousand veterans, in our health care system and have found about 60,000 individuals who are infected with hepatitis C. We have provided our health care providers with guidelines for treatment. There are drugs available, very good drugs that can help treat hepatitis C and prevent the complications and so I would encourage any of you who might be worried about being exposed to this infection to go into your local VA medical center and get screened.

We are also providing a lot of education to our providers. We will have done three national training programs, face to face conferences with our health care providers as of the end of this year. We have done national teleconferences. We have participated with NIH in training programs and with the American Liver Foundation. So VA has been a leader in this area.

Mr. SHAYS. Thank you. Would you tell me what veterans have been most exposed to hepatitis C, what era veteran?

Dr. MURPHY. It appears that there was an epidemic that occurred in the 1960's and early 1970's and the highest rate of hepatitis C appears to occur in Vietnam Era veterans. However, any

veteran who is exposed to infected blood products would be at risk for hepatitis C.

Mr. SHAYS. Let me go to Mr. Tierney in just 1 second. I want to ask these two questions for the record and I would like to know how are the allocations distributed to the facilities in VISN 1? How do you decide what, how they are allocated?

Dr. POST. The process that has been used in the past is the historical information of workload that was done in the prior year and then an adjustment made to that for various incentives that may on in the facility. That has been the allocation up through this fiscal year.

Mr. SHAYS. And is it likely to change in the next few years?

Dr. POST. It is our intent as we move toward better definition of an integrated delivery system to have the resources delivered, some of it will continue to go to the facilities, but the majority of it will be through our care wants.

Mr. SHAYS. Last question. What is the timeframe which VISN 1 hopes to achieve the goals of increasing the number of veterans' users by 5 percent and to decrease the cost by 5 percent?

Dr. POST. This year. We hope to make that achievement this year.

Mr. SHAYS. Thank you.

Mr. Tierney.

Mr. TIERNEY. Thank you. I know how good we are getting because we are not letting the interruptions bother us now. We just go straight through.

Let me just say I understand some veterans need to obtain replacement copies of their discharge forms from the National Veteran Center in order to obtain various services and although turn around time has significantly improved, I understand, there is still quite a backlog. Could you tell us whether or not there are efforts under way to address this particular issue?

Dr. MURPHY. I cannot answer the question specifically about providing the DD214 form, but I will find that information and get back to you.

Mr. TIERNEY. Thank you. Also, the average processing time, I guess, the original compensation claim is about 204.8 days. And I am just curious, are there ways that we can reduce this for veterans. Sometimes these two problems interact and create a significant difficult and I just see that issue coming up over and over again.

Dr. MURPHY. All three of us are with the Veterans Health Administration and the claims processing is administered by the Veterans Benefits Administration which is administratively separated from VHA. However, I know that Joe Thompson, the Under Secretary for Benefits has been taking VBA through a reengineering process.

The waiting times have actually gone up slightly in the past year as they have been training more rating specialists and they knew that their performance would get worse before it got better because as you are training it takes more time and more resources to process a claim, but they expect that with the increased number of rating specialists that are being trained that in a very short period of time processing time for claims should come down. So we are wish-

ing them great luck and we hope that their performance does improve in the very near future.

Mr. TIERNEY. Let me just ask you one last question, you mentioned that the network has a cost per unique patient, as you phrased it. It is approximately \$400 greater than the national average. Would you define for me that unique patient?

Dr. POST. You would like to know the actual cost?

Mr. TIERNEY. When you said that you have one type of patient that was approximately \$400 greater than the national mean you mentioned that it was pertaining to a unique patient. What constitutes a unique patient?

Dr. POST. Actually, that term is referring to a unique Social Security number, so it is per individual and the way we calculate the cost per patient by network is to take the total resource allocation, the number of dollars for Network 1 and divide it by the number of veterans that are being served. So that is the unique veteran.

The allocation is actually done as a basic and a complex patient and the complex patients get almost 10 times the number of dollars that the basic care patients do, so we do make some adjustment for the complexity of the medical care required.

Mr. TIERNEY. Thank you for clarifying that. Let me end, Mr. Chairman, with just a couple of questions about proposed communications.

During your statement you described the new communications council and you mentioned several electronic means of communication. Do we have an estimate of the number of all the veterans that actually use computers? Do we have any statistics on that?

Dr. POST. I do not have the number of veterans who have access to computers. I can tell you that in many of our facilities we are trying to provide them that opportunity.

Mr. TIERNEY. And you have some idea, you must have an idea of how many veterans actually receive your printed newsletter?

Dr. POST. I am sure that we have that number. I just do not have it off the top of my head. I apologize.

Mr. TIERNEY. Since this is going to be the cornerstone of the new VHA where else can veterans obtain information related to the new services, charges of existing services, is there anything else that veterans here and others ought to know about, ways that they can access information?

Dr. POST. Other than the printed material, there is access on the Web to the VISN 1 Website which has lots of information on it about the CBOCs, the services that we provide and what is available to them.

Mr. TIERNEY. Thank you very much. I would like to thank all three of you for your testimony here this morning and for joining us.

Mr. SHAYS. I would just conclude by making this comment. I think the most significant complaints we have from our veterans tend to be with the major facilities, the waits, the bureaucracy and so on. I think and I may find it is different, so I am sharing it with all of you to get your comments when you take to the mic, but I think the biggest area of compliment comes with the community based health care clinics, so it will be interesting to see from our

veterans if that holds up. Is that something, is that consistent with what you are hearing?

Dr. MURPHY. That is actually very consistent with what we hear from veterans at the national level and at the local level. In fact, that is why we chose access and waiting times as a major initiative that we will take on in 2000 and 2001.

Veterans want to be able to get in to see their physician in a short period of time. We have made a commitment that every veteran who calls for a first time primary care appointment will be seen within 30 days and they will be seen for a specialty appointment within 30 days. We know that in many facilities we are not meeting those goals at this point.

Sometimes for services like orthopedic consults or ophthalmology consults or hearing testing, the waits are considerably longer. And in order to help us understand how we can reduce the waiting time for appointments, we have actually worked with the—IHI initiative and it is amazing what we have learned through that.

We have looked at how we have organized clinics. We have found about even changing the number of nurses or doctors assigned to that clinic. In one case we were able to reduce the waiting time from 159 days down to 7 days, just by changing the way the clinic was organized. That is astounding.

So that kind of reengineering and improvement process can provide better service to veterans and it really did not take any increased dollars. It just took a focus on making a change.

Mr. SHAYS. We are preparing to go on to our next panel, but if any of you would like to just make a closing comment, I would be happy to have you do that.

Mr. CONTE. I would just like to thank John and the rest of the people that work with John for the support and we have brought on these clinics. I really do not think we could have done it without the support of congressional people and working with the community and I think that is a real example how the VA should do this in the future.

Mr. SHAYS. Thank you. Dr. Murphy.

Dr. MURPHY. I also want to thank the chairman and all the members of the subcommittee. You have been extremely supportive of the re-engineering process and the transformation of VHA. You have been clear with the Department that what they want to see is better health care to more veterans in a timely way and we thank you for your efforts on behalf of veterans.

Mr. SHAYS. Thank all three of you.

At this time we would call our next panel.

All four of our next panelists are directors of Veterans Services. We have Mr. Robert Hogan, town of Burlington; Mr. Michael Ingham, city of Haverhill; Mr. Donald Welsh, city of Gloucester, and Mr. Jean-Guy Martineau, city of Salem.

Will all four of you gentlemen raise your right hand, please?

[Witnesses sworn.]

Mr. SHAYS. Thank you. Note for the record, all four of our witnesses have responded in the affirmative. And I am going to have you testify in the reverse order I gave you, so Mr. Martineau, I will

have you go first, then Mr. Welsh, then Mr. Ingham and Mr. Hogan, in that order.

STATEMENTS OF JEAN-GUY MARTINEAU, DIRECTOR OF VETERANS SERVICES, CITY OF SALEM; DONALD T. WELSH, DIRECTOR OF VETERANS SERVICES, CITY OF GLOUCESTER; MICHAEL G. INGHAM, DIRECTOR OF VETERANS SERVICES, CITY OF HAVERHILL; AND ROBERT C. HOGAN, DIRECTOR OF VETERANS SERVICES, TOWN OF BURLINGTON

Mr. MARTINEAU. Thank you, Mr. Chairman.

With well over 1,000 visits to the VA I feel qualified to tell you what has taken place in the VA health care system here in the Northeast. Within the past 9 years I have had a first hand look at the Department of Veterans' Affairs health care system.

Daily, the Salem Veterans Services Department provides transportation to local VA medical centers. This includes the VA in Boston, Bedford, West Roxbury, Causeway Street clinic as well as the clinics in Lynn. My visits to these health care centers has brought me into contact with a great number of VA administrators and VA health care providers. I have also worked with VA social workers and patient representatives at the Chelsea Soldiers Home and the New England Shelter for Homeless Veterans in Boston.

The impact of health care restructuring and reallocation of funding priorities has had the "down sizing" effect on the quality of care for veterans. Once a veteran has completed the eligibility process and enrolled in the health care system, he or she will not be seen by a primary care doctor for a month or more. Once they are assigned a primary care doctor, the veteran finds that the doctor is not experienced or is a medical student. I have found this to be particularly true in the mental health clinic in Bedford. Also, with so many foreign doctors, especially in the J.P. hospital, many veterans cannot easily communicate with their doctors. Real communication and patient confidence in their doctors is lacking.

Also medical tests, which are required for proper doctor diagnosis in many cases cannot be given on a timely basis. Recently, one veteran I transported to the VA in February could not get an MRI until this coming May, a 3-month waiting period. I do not think that is good medical care. Beyond the inadequate medical care mentioned, personnel and administrative problems exists, morale among workers is at a long term low.

Down sizing has resulted in many good experienced personnel retiring or having to do two or three additional jobs. This is especially noticeable in the social services and patient support groups. Another major problem caused by "down sizing" is the complete "inaccessibility" of existing medical units.

Long term, in patient nursing home care is for all intents and purposes unavailable. I have one veteran who filed for nursing home care 4 years ago. He is 100 service connected and we are still waiting for him to be admitted. Unfortunately, this case is a good example of the lack of any nursing home care for our veterans.

I have some recommendations. As an experienced and concerned veterans advocate, I would be wrong not to take advantage of this opportunity to offer some recommendations to improve the VA health care system.

Reallocate funding to allow for Bedford VA to provide timely and appropriate nursing home care for all veterans who are 50 percent service connected.

Target increased funding to the directors of Bedford and Boston to make sure that the existing administrative staffs have the funds to provide proper qualified and more experienced doctors and medical care providers.

Provide more bed availability for the in-patient study and inpatient care in the GRECC unit which deals with dementia and Alzheimer health care.

Increase the funding for existing outpatient clinics as well as providing for more neighborhood VA clinics.

Gentlemen, you have only given me 5 minutes to provide testimony on 9 years of travel and first hand knowledge of the VA health care system. Five days of testimony would not be enough. So let me summarize by saying that I would never subjugate myself, a Vietnam veteran, or any member of my family to the VA health care system.

I have always, in the past, in all my work's challenges, where I have spoken or testified had one model and that is "better to light one candle than to curse the darkness," so if I see one hope it is in the newly opened and ever increasing VA clinics in Lynn and in Haverhill.

In ending, I would be remiss if I did not thank Mr. Conte, the director of Bedford and his staff. Although Mr. Conte and I have in many cases agreed and in many cases disagreed, he has always and his staff have always made themselves available to me.


I want to thank Congressman Tierney. I have worked my 9 years with previous Congressmen Marvoulas, previous Congressman Torkelson and now with Congressman Tierney and he is one of the bright stars that represent us in Washington insofar as being a champion of veterans' issues and veterans' concerns and I want to thank Congressman Tierney for that.

And one guy I want to thank that is in the audience and there are many people that I could single out, but you know, with the downsizing of the VA, to get immediately health and direct care, to make a difference, you can it right away if you go to New England Shelter for Homeless Veterans.

Thank you, Tommy Lyons and your staff and also the Chelsea Soldiers' Home. I don't see anybody here from the Chelsea Soldiers' Home, but God bless them too. And I want thank all of you and the chairman and the congressional staff that is here for allowing the veterans to have this opportunity to listen to you, for you to come to us and I want to thank all of the veterans that come here that show enough concern to listen what you have to say. God bless the veteran.

[The prepared statement of Mr. Martineau follows:]

(Testimony of Mr. Martineau)



-1-

WITH WELL OVER A THOUSAND TRIPS TO THE V.A. I FEEL QUALIFIED TO TELL YOU
WHAT HAS TAKEN PLACE IN THE V.A. HEALTH CARE SYSTEM, HERE IN NORTHEAST.
WITHIN THE PAST NINE YEARS, I HAVE HAD A FIRST HAND LOOK AT THE
DEPARTMENT OF VETERANS AFFAIRS HEALTH CARE SYSTEM. DAILY, THE SALEM
VETERANS SERVICES DEPARTMENT, PROVIDE TRANSPORTATION TO LOCAL V.A.
MEDICAL CENTERS. THIS INCLUDES THE V.A. IN BOSTON, BEDFORD, WEST
ROXBURY, CAUSEWAY ST. AND THE CLINIC'S IN LYNN. MY VISITS TO THESE
HEALTH CARE CENTERS HAS BROUGHT ME INTO CONTACT WITH A GREAT
NUMBER OF V.A. ADMINISTRATORS AND V.A. HEALTH CARE PROVIDERS. I HAVE
ALSO WORKED WITH V.A. SOCIAL WORKERS AND PATIENT REPRESENTATIVES AT
THE CHELSEA SOLDIERS HOME AND AT THE NEW ENGLAND SHELTER FOR
HOMELESS VETERANS , IN BOSTON.
THE IMPACT OF HEALTH CARE RESTRUCTURING AND THE REALLOCATION OF
FUNDING PRIORITIES HAS HAD THE "DOWN SIZING" EFFECT ON THE QUALITY OF
CARE FOR VETERANS: ONCE A VETERAN HAS COMPLETED THE ELIGIBILITY
PROCESS AND ENROLLED INTO THE HEALTH CARE SYSTEM, HE OR SHE WILL NOT
BE SEEN BY A PRIMARY CARE DOCTOR FOR A MONTH OR MORE.

ONCE THEY ARE ASSIGNED A PRIMARY CARE DOCTOR, THE VETERAN FINDS THAT THE DOCTOR IS NOT EXPERIENCED OR IS ONLY A MEDICAL STUDENT. I FOUND THIS TO BE PARTICULARLY TRUE IN THE MENTAL HEALTH CLINIC, IN BEDFORD. ALSO WITH SO MANY FOREIGN DOCTORS, MANY VETERANS CANNOT EASILY COMMUNICATE WITH THEIR DOCTORS. REAL COMMUNICATION AND PATIENT CONFIDENCE IN THEIR DOCTOR IS LACKING.

ALSO MEDICAL TESTS, WHICH ARE REQUESTED FOR PROPER DOCTOR DIAGNOSIS, IN MANY CASES CANNOT BE GIVEN ON A TIMELY BASIS. RECENTLY, ONE VETERAN I TRANSPORTED TO THE V.A. IN FEBRUARY COULD NOT GET AN M.R.I. UNTIL MAY (A 3 MONTH WAITING PERIOD) IS THIS GOOD MEDICAL CARE? BEYOND THE INADEQUATE MEDICAL CARE MENTIONED, PERSONNEL AND ADMINISTRATIVE PROBLEMS EXISTS, MORALE AMONG WORKERS IS AT A LONG TIME LOW. DOWN SIZING HAS RESULTED IN MANY GOOD EXPERIENCED PERSONNEL RETIRING OR HAVING TO DO TWO OR THREE ADDITIONAL JOBS. THIS IS ESPECIALLY NOTICEABLE IN THE SOCIAL SERVICES AND PATIENT SUPPORT GROUPS. ANOTHER MAJOR PROBLEM CAUSED BY "DOWN SIZING" IS THE COMPLETE "INACCESSIBILITY" OF EXISTING MEDICAL UNITS.

LONG TERM, IN PATIENT NURSING HOME CARE IS FOR ALL INTENTS AND
PURPOSED UNAVAILABLE. I HAVE ONE VETERAN WHO FILED FOR NURSING
HOME CARE FOUR YEARS AGO. HE IS 100% SERVICE CONNECTED AND WE ARE
STILL WAITING TO SEE HIM BEING ADMITTED. UNFORTUNATELY, THIS CASE IS A
GOOD EXAMPLE OF THE LACK OF ANY NURSING HOME CARE FOR OUR VETERANS.

RECOMMENDATIONS:

AS AN EXPERIENCED AND CONCERNED VETERANS ADVOCATE, I WOULD BE
WRONG NOT TO TAKE ADVANTAGE OF THIS OPPORTUNITY TO OFFER SOME
RECOMMENDATIONS TO IMPROVE ON V.A. HEALTH CARE.

1. REALLOCATE FUNDING TO ALLOW FOR BEDFORD V.A. TO : PROVIDE TIMELY
AND APPROPRIATE "NURSING HOME CARE" FOR ALL VETERANS WHO ARE OVER
50% SERVICE CONNECTED.

TARGET INCREASED FUNDING TO THE DIRECTORS OF BEDFORD AND BOSTON TO
MAKE SURE THAT THE EXISTING ADMINISTRATIVE STAFFS HAVE THE FUNDS TO
PROVIDE BETTER QUALIFIED AND MORE EXPERIENCED DOCTORS AND MEDICAL
CARE PROVIDERS.

PROVIDE MORE BED AVAILABILITY FOR THE INPATIENT STUDY AND INPATIENT CARE IN THE G.R.E.C.C. UNIT WHICH DEALS WITH DEMENTIA AND ALZHEIMER HEALTH CARE.

INCREASE THE FUNDING FOR THE EXISTING OUTPATIENT CLINICS AS WELL AS PROVIDE FUNDING FOR MORE NEIGHBORHOOD V.A. CLINICS.

GENTLEMEN, YOU HAVE GIVEN ME ONLY FIVE MINUTES TO PROVIDE TESTIMONY ON NINE YEARS OF TRAVEL AND FIRST HAND KNOWLEDGE OF THE V.A. HEALTH CARE SYSTEM. FIVE DAYS OF TESTIMONY WOULD NOT BE ENOUGH.

SO LET ME SUMMARIZE BY SAYING THAT I WOULD NEVER SUBJUGATE MYSELF OR ANY MEMBER OF MY FAMILY TO V.A. HEALTH CARE.

FINALLY I HAVE ALWAYS, IN ALL MY WORK'S CHALLENGES, HAD ONE MOTTO:

"IT IS BETTER TO LIGHT ONE CANDLE, THEN TO CURSE THE DARKNESS..."

SO, IF I SEE ANY HOPE, IT IS IN THE NEWLY OPENED AND EVER INCREASING V.A. CLINICS IN LYNN AND HAVERHILL.

Mr. SHAYS. God bless the veteran and thank you.

[Applause.]

Mr. SHAYS. Mr. Welsh, if you would just get that mic and just lower it down a bit.

Mr. WELSH. Mr. Chairman, Congressman Tierney, fellow veterans, ladies and gentlemen, good morning.

My name is Don Welsh, as has been mentioned. I am the director of Veterans' Services for the beautiful city of Gloucester, MA and I do appreciate the opportunity to address this committee about the State of VA health care in my area of Massachusetts which I will refer to as Cape Ann. Having spent 24 years in the Marine Corps I can tell you I thoroughly enjoy taking care of veterans and the more we can do for the veteran, the better.

Let me start by saying the status of VA health care for the veterans I represent is generally speaking not good and it is getting worse. But I have a reason for saying that. It is because of the difficulty for veterans of Cape Ann to get to VA health care facilities. There are none in Cape Ann. Thus, these veterans have to travel many miles to the nearest facility after waiting a lengthy period for an appointment and often have to go back for a second or third time to complete treatment.

What we need is a community based outpatient clinic [CBOC], in my area. You have heard a lot about that already this morning. I am well aware of the CBOCs that in recent years were opened in Haverhill and Lynn and the great relief they provided for the veterans in and near those cities. And as you have already heard, thanks to Congressman Tierney and his staff, application for a CBOC in my area has been made. How great it would be to open a VA clinic in Gloucester to service our aging veteran population which finds it more and more difficult to get around.

Let me point out that in my city of Gloucester there is a higher percentage of veterans per capita than anywhere else in Massachusetts. It has been calculated that the average number of veterans in relation to the overall population of each city in Massachusetts is about 11 percent. In Gloucester, the veteran population is about 21 percent.

And as I have mentioned it is an aging population. World War II veterans are in their late 70's or 80's and the Korean War Era vets are not far behind. It is very difficult for them to travel long distances for VA treatment. Many of them just go without much needed services, rather than make repeated trips to a VA facility.

As Tom Brokaw so eloquently wrote in his book, "The Greatest Generation," which was about World War II veterans, "They persevered through war . . . and then went to create interesting and useful lives in the America we have today . . . They answered the call to save the world from the two most powerful and ruthless military machines ever assembled . . . but they did not protest. They won the war; they saved the world."

Now, these veterans and veterans of other conflicts need our help. They need better health care services and the VA can and should be the instrument for those services. Let us not let our veterans down.

As everyone knows, HMOs are cutting back on providing prescription drugs and this is becoming a real burden for many of our

veterans, particularly those who are on fixed incomes. This is an area where the VA can pick up the torch and provide relief. But in order to do so we need more facilities, staff and dollar resources.

Another area that should be addressed is the need to provide dental care for our veterans. Today, that service is almost nonexistent. I get inquiries every week from veterans about availability of dental care, but very few veterans are eligible under current rules for such VA health care. With skyrocketing dental costs and again with an aging veteran population, a more liberal dental policy should be adopted by the VA.

I will close with a request for another area to be addressed by this committee. It concerns communication by or about VA health care services. What I am experiencing these days with veterans who are being discharged from active duty is that many are not informed about the VA services available to them. It should be a mandatory policy that every member of the Armed Forces be given a Veterans' Affairs briefing prior to release from active duty. If that is a policy, it is not working in many cases. As a result, veterans are missing out on benefits, particularly in the health services area.

Thank you very much.

[The prepared statement of Mr. Welsh follows:]

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CITY OF GLOUCESTER, VETERANS' SERVICES

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April 3, 2000

Subcommittee on National Security, Veterans Affairs,
and International Relations
Room B-372 Rayburn Building
Washington, D.C. 20515

Below is my testimony for the April 10th Subcommittee field hearing on quality of care in VA health facilities.

My name is Don Welsh, director of veterans services for the city of Gloucester, Massachusetts. I appreciate the opportunity to address this committee about the state of VA health care in my area of Massachusetts which I will heretofore call the Cape Ann Area. Having spent 24 years in the Marine Corps I can tell you I thoroughly enjoy taking care of veterans and the more we can do for them, the better.

Let me start by saying the status of VA health care for the veterans I represent is not good and is getting worse. The reason I say that is because of the difficulty for veterans of Cape Ann to get to VA health care facilities. There are none in Cape Ann thus they have to travel many miles to the nearest facility after waiting a lengthy period for an appointment and often have to go back for a second or third time to complete treatment.

What we need is a Community Based Outpatient Clinic (CBOC) in my area. I am well aware of the CBOC's that in recent years were opened in Haverill and Lynn and the great relief they provided for the veterans in and near those cities. I know that, thanks to Congressman Tierney, application for a CBOC in my area has been made. How great it would be to open a VA clinic in my area to service our aging veteran population which finds it more and more difficult to get around.

Let me point out that in my city of Gloucester there is a higher percentage of veterans per capita than anywhere else in Massachusetts. It has been calculated that the average number of veterans in relation to the overall population of each city in Massachusetts is about 11 percent. In Gloucester the veteran population is 21 percent. And, as I mentioned above, it is an aging population. World War II veterans are in their late 70's or 80's and the Korean era vets are not far behind. It is very difficult for them to travel long distances for VA treatment. Many of them just go without must needed services rather than make repeated trips to a VA facility. As Tom Brokaw so eloquently wrote in his book, "The Greatest Generation," (about WW II veterans) "They persevered through war....and then went on to create interesting and useful lives and the America we have today...They answered the call to save the world from the two most powerful and ruthless military

machines ever assembled....but they did not protest. They won the war; they saved the world.”

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As everyone knows, HMO's are cutting back on providing prescription drugs and this is becoming a real burden for many of our veterans, particularly those who are on fixed incomes. This is an area where the VA can pick up the torch and provide relief. But, in order to do so we need more facilities, staff and dollar resources.

Another area that should be addressed is the need to provide dental care for our veterans. Today that service is almost non existent. I get inquiries every week from veterans about availability of dental care but, very few veterans are eligible, under current rules, for such VA health care. With skyrocketing dental costs and, again, with an aging veteran population, a more liberal dental policy should be adopted by the VA.

I will close with a request for another area to be addressed by this committee. It concerns communication by or about VA health care services. What I am experiencing these days with veterans who are being discharged from active duty is that many are not informed about the VA services available to them. It should be a mandatory policy that every member of the armed forces be given a Veterans Affairs briefing prior to release from active duty. If that is a policy now it's not working in many cases. As a result, veterans are missing out on benefits, particularly in the health services area.

Thank You.

Mr. TIERNEY. Your last suggestion is something that we will just separate right now and we will write a letter to the Secretary of Defense and those who have direct responsibility. It is an excellent idea. If it is happening, I am not sure if it is a requirement. I agree, I am not sure it is happening. And we will make sure that that is something we deal with right away when we get back. It is an excellent suggestion.

Mr. WELSH. Thank you, Mr. Chairman.

Mr. SHAYS. Mr. Ingham.

Mr. TIERNEY. I have already tasked one of my task. I will have her announce her name later, so if it does not happen, you will know who to call.

Mr. INGHAM. Congressman Shays, Congressman Tierney, fellow veterans, the ROTC students here—I just left 2 weeks at the Air Force Academy, the Air Force Reserves and hopefully, you students will attend that college and serve.

As the Veterans Services director for the city of Haverhill, MA, one of the most common requests from veterans of my office is assistance with medical care and prescriptions.

With this in mind, I was very fortunate to meet William Conte, the director of the Bedford VA and formulate plans for health care services for veterans outside of the Bedford Hospital. These were dramatic steps for the VA to go outside the traditional system of providing care and bring health care services directly to the veterans in their community.

The first step was to develop a survey to define the health needs of the veterans and what issues that might be preventing them from using the VA health care service. Along with local organizations, the Veterans Council of Haverhill, we held a health day with medical teams from the Bedford VA Hospital. Over 700 veterans and their families attended.

The results of the survey indicated that a lack of knowledge of the VA system and services that were available was the primary reason for not using the VA. The second problem identified was transportation as many of the veterans were elderly, driving to distant VA facilities was too difficult. The survey also showed priorities of care that the veterans would utilize. The most overwhelming need was assistance with prescriptions. An interesting point of the survey was the income level; many veterans earn under \$25,000 annually. Many veterans identified needs that related directly to age such as ophthalmology, cardiology, urology and rheumatology.

With the health needs established, transportation issues to address and education priorities outlined, we brought our findings to Dr. Fitzgerald, the director of the New England Health Care System for submission to the VA for congressional consideration.

Thanks to the support of Congressman Tierney, local and State officials, veterans organizations, the Veterans Outreach Center and Veterans Services of Haverhill, we were able to approve as a site for a veterans community based outpatient clinic.

With staffing from the Bedford VA Hospital and site work completed, the Haverhill Clinic opened in November 1998 at the city-owned Hale Hospital. The staff members, half of whom work part-time out of the Bedford VA, the clinic is now serving over 1,200

veterans. With new patients enrolling daily, staff and services continue to increase with the demand.

Substance abuse and psychological care is now available twice a week and plans are to expand the service with added space when available. Issues such as agent orange and the Gulf War Syndrome, as well as assistance with VA compensation claims can be addressed at the clinic. The Haverhill Clinic staff often assists agents with placement for substance abuse, Post Traumatic Stress Disorder treatment, often while the veteran is in the Veterans Services Office and in need of immediate help.

The clinic is only primary outpatient care, but importantly the Haverhill Clinic is tied into a network of extensive health care between the Bedford VA and the Boston VA hospitals. The clinic provides accessibility to a coordinated and a continuity of care with courtesy, family involvement and patient education. In a new era of health care, the VA must reach veterans and educate them on their benefits, and we in the service of veterans are responsible to do the best we can to see that they receive the benefits available.

The Haverhill Community Based Outpatient Clinic has dramatically impacted the veterans of Haverhill as well as other communities in the Merrimack Valley and lower New Hampshire. The overwhelming response of the veterans using the clinic is that they are totally satisfied with the treatment they received, both personally as well as physically.

Dr. Balse and his staff have done an outstanding job providing health services to veterans that should be used as an example for future clinics throughout the country. I have had veterans tell me how much their lives have changed with the care they are now receiving at the Haverhill Veterans Outpatient Clinic.

Some feel their lives were saved as a direct result of visiting the clinic. I know of one veteran that thought he was in good health, and upon a visit to the clinic found he had a life threatening heart condition that resulted in cardiac surgery that was performed by the VA doctors at Jamaica Plains, Boston.

The pharmacy program is probably the most used service at the clinic. Medications are requested by the primary doctor and filled by mail from the Bedford pharmacy. Veterans are saving substantially on medications enabling them to lead healthier lives as well as a better standard of living.

Bedford, Lynn and Haverhill, due to the marriage of health care services provided over 190,000 visits to veterans in 1999, in these hospitals alone. That equals to approximately three visits per veteran in the system. This is a dramatic result for 1 year in business and we have only reached approximately 15 percent of the 36,000 veterans in the Merrimack Valley.

As I mentioned earlier, transportation is a primary reason veterans are not taking advantage of the VA health care system. Many veterans with illnesses depend on family members to take them for medical treatment. This is a stress on the entire family, not just the veteran.

With the clinic centrally located in the Merrimack Valley, many veterans are able to take advantage of care they often went without. Haverhill is very fortunate to have a van and a driver under the Department of Veterans' Services to take veterans to the VA

hospitals. The Northeast Veterans Outreach Center is also under the Department of Veterans' Services, provides transportation to the clinic with a van donated by the Massachusetts Department of Disabled American Veterans.

Haverhill also provides transportation through the Department of Human Services. This is free transportation for Haverhill's elderly, handicapped and veteran residents. Transportation is available from the Haverhill Clinic to the Bedford VA with a daily shuttle. Haverhill also has the MVRTA bus system.

The problem for veterans outside of Haverhill is getting to the clinic as well as transportation to VA hospitals in Boston. Expanded public transportation, discounts for existing transportation, or grants to towns and cities to provide limited transportation for veterans will make it possible for them to take advantage of the health services available.

It is in our best interest to see that veterans are made aware of the advantages of the New England health care system. Prevention and treatment will ensure healthier and more productive lives and save on taxpayers in the future. Many veterans have service related injuries both physically, as well as psychologically, the Haverhill Clinic fulfills and obligation to them for their service to our Nation with the best health care we can provide.

We are here today to request of you to express to Washington that it is imperative to maintain the quality of our VA health care system and to see that adequate funds are there in the new millennium for a generation that preserved the freedom of this country that all of us in the 21st century will hopefully enjoy.

I wish to close by thanking you for listening to our comments today and commend you for your efforts to best serve all veterans of the U.S. Armed Forces.

Thank you.

[The prepared statement of Mr. Ingham follows:]

#H



James A. Rurak
Mayor

Vincent R. Ouellette
Director of Human Services

CITY OF HAVERHILL
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Michael G. Ingham
Director

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The first step was to develop a survey to define the health needs of the Veterans and what issues that might be preventing them from using the VA Health Care System. Along with local Veterans Organizations, we held a Health Day with medical teams from the Bedford VA Hospital. Over seven hundred Veterans and their families attended. The results of the survey indicated that a lack of knowledge of the VA system and services that are available was the primary reason for not using the VA. The second problem identified was transportation, as many of the Veterans were elderly, driving to distant VA facilities was too difficult. The survey also showed priorities of care that the Veterans would utilize. The most overwhelming need was assistance with prescriptions. An interesting point of the survey was the income level; many Veterans earn under \$25,000 annually. Many Veterans identified needs that related directly to age such as Ophthalmology, Cardiology, Urology, and Rheumatology.

With the health needs established, transportation issues to address and education priorities outlined, we brought our findings to Dr Fitzgerald, Director of the New England Health Care System for submission to the VA for Congressional consideration. Thanks to the support of Congressman Tierney, local and State Officials, Veterans Organizations, the Veterans Outreach Center and Veterans Services, Haverhill was approved as a site for a Veterans Community Based Outpatient Clinic.

With staffing from the Bedford VA Hospital and site work completed, the Haverhill Clinic opened in November of 1998 at the City owned Hale Hospital. The clinic occupies a wing of eight rooms on the second floor of the Hospital. There are 10 staff members, half of whom work part time out of the Bedford VA. The Clinic is now servicing over 1200 Veterans. With new patients enrolling daily, staff and services continue to increase with the demand. Substance abuse and psychological care is now available twice a week and plans are to expand the service with added space when available. Issues such as Agent Orange and the Gulf War syndrome as well as assistance with VA compensation claims can be addressed at the Clinic. The Haverhill Clinic staff often assists agents with placement for substance abuse and Post Traumatic Stress

Disorder treatment, often while the Veteran is in the Veterans Services office and in need of immediate help.

The Clinic is only primary outpatient care but importantly the Haverhill Clinic is tied into a network of extensive health care between the Bedford VA and the Boston VA Hospitals. The Clinic provides accessibility to a coordinated and a continuity of care with courtesy, family involvement and patient education. In a new era of health care the VA must reach Veterans and educate them on their benefits, and we in the service of Veterans are responsible to do the best we can to see they receive the benefits available.

The Haverhill Community Based Outpatient Clinic has dramatically impacted the Veterans of Haverhill as well as other Communities in the Merrimack Valley and lower NH. The overwhelming response of the Veterans using the clinic is that they are totally satisfied with the treatment they receive both personally as well as physically. Dr. Balse and his staff have done an outstanding job, providing health services to Veterans that should be used as an example for future clinics throughout the Country. I have had Veterans tell me how much their lives have changed with the care they are now receiving at the Haverhill Veterans Outpatient Clinic. Some feel their lives were saved as a direct result of visiting the clinic. I know of one Veteran that thought he was in good health, and upon a visit to the clinic found he had a life threatening heart condition that resulted in Cardiac surgery that was performed by the VA doctors at Jamaica Plains, Boston.

The pharmacy program is probably the most used service at the clinic. Medications are requested by the primary doctor and filled by mail from the Bedford pharmacy. Veterans are saving substantially on medications enabling them to lead healthier lives as well as a better standard of living.

Bedford, Lynn and Haverhill due to the marriage of health care services provided over one hundred and ninety thousand visits to Veterans in 1999, in these hospitals alone. That equals to approximately three visits per Veteran in the system. This is a dramatic result for one year in business and we have only reached approximately fifteen per cent of the thirty six thousand Veterans in the Merrimack Valley.

As I mentioned earlier transportation is a primary reason Veterans have not taken advantage of the VA Health Care System. Many Veterans with illnesses depend on family members to take them for medical treatment, this is a stress on the entire family not just the Veteran. With the clinic centrally located in the Merrimack Valley many Veterans are able to take advantage of care they often went without. Haverhill is very fortunate to have a van and a driver under the department of Veterans Services to take Veterans into the VA Hospitals. The Northeast Veterans Outreach Center also under the Department of Veterans Services provides transportation to the Clinic with a van donated by the Massachusetts Department of Disabled American Veterans. Haverhill also provides transportation through the Department of Human Services; this is free transportation for Haverhill's elderly, handicapped and veteran residents. Transportation is available from the Haverhill Clinic to the Bedford VA with a daily shuttle. Haverhill also has the MVRTA Bus system. The problem for Veterans outside of Haverhill is getting to the clinic as well as transportation to VA Hospitals in Boston. Expanded public transportation, discounts for existing transportation, or grants to towns and cities to provide limited transportation for Veterans will make it possible for them to take advantage of the health services available.

It is in our best interest to see that Veterans are made aware of the advantages of the New England Health Care System. Prevention and treatment will ensure healthier and more productive lives and save on tax- payers in the future. Many Veterans have service related injuries both physically as well as psychologically, the Haverhill Clinic fulfills an obligation to them for their service to our nation with the best health care we can provide.

We are here today to request of you to express to Washington that it is imperative to maintain the quality of our VA health Care System. And to see that adequate funds are there in the new millenium for a generation that preserved the freedom of this country that all of us in the 21st Century will hopefully enjoy.

I wish to close by thanking you for listening to our comments today and commend you for your efforts to best serve all Veterans of the United States Armed Forces.

Sincerely,


Michael G. Ingham
Director

Mr. SHAYS. Thank you, Mr. Ingham.

Mr. Hogan.

Mr. HOGAN. Chairman Shays, Congressman Tierney, Mr. Conte, ladies and gentlemen and fellow veterans, thank you for allowing me the opportunity to discuss the impact of VA health care service restructuring and resource allocation in the delivery and quality of health care.

I have three areas that I intend to address here today, one being long term care for our veterans, another is continued access to VA health care services for all veterans, and finally and briefly, some comments on hepatitis C care and funding.

We need to make sure that the VA health care system is sound enough and funded well enough, not for the healthy among us, but for those among us that hope for quality health care during their journey through this life and at the end of our life. We need to live up to the promises and expectations of our elderly veterans who need the coverage that the VA health care system promised them, over the five, six or seven decades.

That coverage may take several forms, such as VA nursing home care, community based nursing home care, and nursing care for the veterans in their own home. But we cannot be told that there is no room at the inn or that specific alternative care that is promised has not yet be established or funded.

The funding for the new Millennium Health Care and Benefits Act should be applauded for its beginnings, but it must continue to grow and expand with the very increasing needs of our veterans as they age and need proper medical care.

In the March edition of VFW Magazine, Republic Congressman Bob Stump stated that this health care package is a blueprint for the next century. Well, that sounds good, but without the required funding, the blueprint will sit and collect dust and the lack of funding can in no way diminish the VA's obligation to maintain and deliver proper and appropriate health care to our veterans. And it is the responsibility of every Member of Congress to help the VA meet this obligation. In that same edition, Democratic Congressman Lane Evans reaffirmed Congress' proud support for our Nation's veterans.

Now comes the difficult task of trying to wed that concept to reality. The passage of the Veterans Millennium Health Care and Benefits Act in November of this past year has good direction, but there needs to be significant plans on how to get to the goals stated, and money is one key component in that plan.

The bill directs that the VA operate and maintain a national program of extended care services including geriatric evaluations, nursing home care, both in-house and contract, adult day care, domiciliary care and respite care. With a national nursing home crisis we are seeing nursing homes closing due to cutbacks in Federal funding. In Massachusetts alone, 93 of the State's 580 nursing homes are already in bankruptcy with 13 homes closing over the past 2 years.

The VA should not depend on there being enough good quality nursing homes available and with there being almost 5,000 complaints against nursing homes sin this State alone last year, the

good quality part of that equation is also in doubt. The VA should not be dumping its veterans out to lesser quality care.

The Millennium Health Care Act requires the VA to develop and begin to implement a plan for carrying out the recommendations of the Federal Advisory Committee on the Future of Long Term Care, and that the VA increase both home care and community based care options.

The elderly veterans who need this care now are the builders of this great society. They sacrificed in war and they sacrificed in peace and now just because they have aged does not mean the VA and this country can forget them. They are an important part of this great society and they have earned the right to expect to be treated with dignity and be accorded the care any decent society can afford, not years from now.

Throughout the 20th century, brave young men and women, young boys and girls actually, who gave up their youth and the comfort of their home and the safety of their families volunteered and were drafted to serve their country and on many occasions either died or were injured because of that service to their country. And what is not in the testimony, Mr. Chairman, if I could just remember the 19 Marines who passed away this weekend and note that service to this country can be hazardous both here and around the world, both in peace and in war.

Throughout America's history, American veterans have served and served well. They saw democracy challenged, here and around the world and they defended it. They saw civilization threatened here and around the world and they rescued it. They saw human rights endangered and they sought to restore them.

Their heroism was prompted by faith in the fundamentals that have guided this Nation from its beginnings. The idea was that liberty must be protected, whatever the cost. And the VA health care system owes that same dedication to those men and women, whatever the cost.

And the VA must consider itself a supplier of a service and that customer satisfaction is their top priority. The VA must develop a communication plan so that anyone and everyone at the VA who answers the telephone or sits at a desk must know what the game plan is and where the resources are for the veterans and their families and the VA must be user friendly. The VA must be veteran friendly.

And Congress to guarantee permanent funding for all veterans. We cannot continue to inflict emotional distress upon the veterans who qualify for VA health care, that they will not have this taken away from them based simply on cost considerations.

There is a health care prescription medicine crisis in the broader health care structure that affects the VA health care system. Many veterans who have private health insurance have no prescription coverage for the drugs they need. Even in our most extensive public insurance program, Medicare, three out of five seniors in this country do not have dependable drug coverage.

According to a recent report from the House Government Reform Committee of which both Congressman Tierney and Congressman Shays are members, drug companies charge older Americans discriminatory prices. Seniors in many parts of this country, including

New England, are being forced to pay on average, more than twice as much for prescription drugs than other customers.

Health care is one of the most important issues in this country today. And it is so because of the explosion of health care crises around the country. Present and future health care crises will send veterans to the VA in droves to secure the proper health care. The VA will need to be ready to handle that need and the VA must continue to provide care to the veterans that has been promised to them, that VA health care must provide quality care to the right patient at the right time and at the right level of care.

If we do not take dramatic steps now to address these issues, it will only be harder for us down the road to be more diligent to ensure good quality care for our aging veterans.

And finally and quickly I would like to comment about hepatitis C care and funding. Hepatitis C is a fairly new, yet very disturbing medical risk and the veterans are on the high side of the curve when it does come to those infected, as you heard us talk earlier. It is also very costly and it will be a major impact on the VA budget line item. Treatment can be expected to run a minimum of \$10,000 per year for each veteran infected with the disease and future prevention and treatment to try and prevent additional damage to one's liver are also considerable. It is on the radar screen for one very good reason. It is important.

Thank you for allowing me this opportunity to address these issues.

[The prepared statement of Mr. Hogan follows:]

Testimony Given to: The Subcommittee on National Security, Veterans Affairs, and International Relations
 Given by: Robert C. Hogan, Director of Veterans Services, Burlington, Massachusetts
 Given at: Peabody High School, Monday, April 10, 2000

Chairman Shays, Congressman Tierney, Ladies and Gentlemen.

Thank you for allowing me the opportunity to discuss the impact of VA Health Care Service Restructuring and Resource Allocation in the delivery and quality of health care. I have three areas that I intend to address here today: one being long term care for our veterans, another is continued access to VA Health Care Services for all veterans and finally and briefly some comments on Hepatitis C, care and funding.

We need to make sure that the VA Health Care System is sound enough and funded well enough, not for the healthy among us, but for those among us that hope for quality health care during their journey through life and at the end of their life. We need to live up to the promises and expectations of our elderly veterans who need the coverage that the VA health care system promised them, over the past five decades.

That coverage may take several forms, such as VA Nursing Home Care, Community Based Nursing Home Care, and Nursing care for the veteran in their own home. But, we cannot be told that there is no room at the Inn, or that specific alternative care that is promised has not yet been established or funded.

The funding for the new Millennium Health Care and Benefits Act should be applauded for their beginnings, but it must continue to grow and expand with the ever increasing needs of our veterans as they age and need proper medical care. In the March edition of VFW Magazine, Republican Congressman Bob Stump stated that this health care package is a blueprint for the next century. That sounds good, but without the required funding, the blueprint will sit and collect dust. The lack of funding can in no way diminish the VA's obligation to maintain and deliver proper and appropriate health care to our veterans. And it is the responsibility of every member of Congress to help the VA meet that obligation. In that same edition, Democratic Congressman Lane Evans reaffirmed Congress's proud support for our nation's veterans.

Now comes the difficult task of trying to wed that concept to reality. The passage of the Veterans Millennium Health Care and Benefits Act in November of this past year has good direction, but there needs to be significant plans on how to get to the goals stated, and money is one key component in that plan.

The bill directs, that the VA operate and maintain a national program of extended care services, including geriatric evaluations, nursing home care, (both in-house and contract), adult day care, domiciliary care, and respite care. With a national nursing home crisis we are seeing nursing homes closing due to cutbacks in federal funding. In Massachusetts alone, 93 of the states 580 nursing homes are already in bankruptcy, with 13 homes closing over the past two years. The VA should not depend on there being enough good quality nursing homes available, and with there being almost 5,000 complaints against nursing homes in this state alone, last year, the good quality part of the equation is also in doubt. The VA should not be dumping it's veterans out to lesser quality care.

The Millennium Health Care Act requires the VA to develop and begin to implement a plan for carrying out the recommendations of the Federal Advisory Committee on the Future of Long Term Care, and that the VA increase both home and community based care options.

The elderly veterans who need this care now are the builders of this great society. They sacrificed in war, and they sacrificed in peace, and now just because they have aged, does not mean the VA, and this country can forget them. They are an important part of this great society and they have earned the right to expect to be treated with dignity and be accorded the care any decent society can afford, now, not years from now.

Throughout the twentieth century, brave young men and women, young boys and girls actually, who gave up their youth and the comfort of their home and the safety of their families, volunteered, or were drafted, to serve their country and on many occasions either died or were injured because of that service to their country.

Without this sacrifice, we would not be basking in prosperity today here in this great country. It is easy to overlook how close we came to losing so much back during World War 2, and how much, so many people around the world could have lost, but for the service and duty of young American men and women.

We cannot forget the sacrifice of all the young men and women who have worn the uniform of this great country, yet, we forget the promises made to them. Testifying before the United States Senate recently, Defense Secretary William Cohen

stated that it is a moral obligation that this country take care of all of those who served, just as Abraham Lincoln said more than 135 years earlier, when he said that we must never forget those who bore the burden of battle.

But it is easy to forget. After all the economy continues to boom and the stock market remains high. But our security and freedom are gifts, given by the young men and women who have, and continue to, put themselves in harm's way, whether in war or in peace, here and around the world.

Throughout history, America's veterans have served and served well. They saw democracy challenged, here and around the world, and they defended it. They saw civilization threatened, here and around the world, and they rescued it. They saw human rights endangered and they sought to restore them.

Their heroism was prompted by faith in the fundamentals that have guided this nation from its beginnings. The idea was that liberty must be protected, whatever the cost. And the VA Health Care System owes that same dedication to these men and women, whatever the cost.

The VA must consider itself a supplier of a service, and that customer satisfaction is their top priority. The VA must develop a communication plan so that anyone and everyone at the VA who answers a telephone or sits at a desk must know what the game plan is, and where the resources are, that are available for the veterans and their families. The VA must be user friendly. The VA must be veteran friendly.

Martin Luther King once said, "The ultimate measure of a man is not where he stands in moments of comfort and convenience, but where he stands in times of challenge and controversy." You can measure the men and women in this room, across this state and throughout this great country who are veterans, by where they stood, in times of trouble and hardship. And I am honored to say that as a veteran, I proudly stand with them.

Seen today as a success, the VA Health Care System should be a model for other health care delivery systems. Many people call it one of this country's finest social policy achievements, and should be used not only as a model for other programs, but as a partner in, and part of the larger slice of the delivery of health care to the citizens of this great country. If we are truly concerned about a continuum of care for our veterans we need to look towards combining programs, such as The VA Health Care System, Medicare and Medicaid funding and the Medical Care provided to all active duty military and federal government employees, as a start.

Congress needs to guarantee permanent funding for all veterans. We cannot continue to inflict emotional distress upon the veterans who qualify for VA Health Care, that they will have this safety net taken away from them, based on cost considerations, or that they will be the victims of "The Law of Unintended Consequences."

There is a health care/prescription medicine crisis, in the broader health care structure that affects the VA health care system. Many veterans who have private health insurance have no prescription coverage for the drugs they need. Even in our most extensive public insurance program, Medicare, three out of five seniors in this country do not have dependable drug coverage.

Currently, even those who are enrolled in Medicare managed care organizations have either limited or no access to prescription drug coverage. Many Medicare Managed Care Plans are capping their coverage at \$1,000 or even \$500.00.

According to a recent report from the House Government Reform Committee, of which Congressman Tierney and Congressman Shays are members, and a recent study by Standard and Poor's, -- Drug companies charge older Americans discriminatory prices. Seniors in many parts of the country, including New England, are being forced to pay on average, more than twice as much for prescription drugs as other customers, such as the large insurance companies.

Private prescription drug expenditures have been growing at a rate of 17 % a year. More than one-third of all seniors have no health care coverage to help pay for medications. And too many of our senior veterans have to make life and death decisions about which meds they can afford to buy and which ones they might do without.

Health care is one of the most important issues in this country today. And it is so, because of the explosion of the health care crises around the country. Present and future health care crises will send veterans to the VA in droves to secure the proper health care. The VA will need to be ready to handle that need and the VA must continue to provide care to the veterans that has been promised to them over the past 50 years. VA health care must provide quality care to the right patient at the right time and at the right level of care.

If we do not take dramatic steps now to address these issues, it will only be harder for us down the road to be more

diligent in ensuring good quality health care for our aging veterans.

And there are too many barriers set up to keep veterans from easily moving to the VA for their medical care. There is still the reluctance and hesitation by veterans to separate themselves from the civilian medical care that he, his wife and family share. The veterans and his or her family must be made aware of not only the services available, but the quality of those services. Communicating with the veteran community, and marketing the program better, must be a priority. Even today, not every veteran is aware of his rights and what is available to him or her, through the VA Health Care System.

And we must always remember that what we do here and now, affects not only the veterans but his or her spouse and their family. We are not only looking at the more than 600,000 veterans here in Massachusetts, but the more than two million people who are directly affected by our decisions and our actions.

And Congress must look at the referral system presently in place that will preclude a third party insurance company from reimbursing the VA for a veterans care. A civilian Primary Care Physician associated with an HMO is not going to send a patient to another Primary Care Physician at the VA and ask the insurance carrier to then send money to the VA instead of his own practice. In order to get more veterans to utilize the VA Health Care System, we must eliminate all the obstacles.

And to that end, the Congress must properly fund the VA Health Care System, so that they may properly care for our veterans. And this cannot be accomplished by publishing reports that state large decreases in funding are necessary for VA health care to survive, all the while stating that there are increased expectations of usage by veterans.

Quickly and finally, about Hepatitis C care and funding. Hepatitis C is a fairly new yet very disturbing medical risk and veterans are on the high side of the curve when it comes to those infected with the disease. It is also very costly. It will have a major impact on a VA budget line item. Treatment can be expected to run a minimum of \$10,000 per year for each veteran infected with the disease. And future prevention and treatment to try and prevent additional damage to one's liver are also considerable. It is on the radar screen for a very good reason. It is important.

Thank You for allowing me the opportunity to address you on these most important issues.

Mr. SHAYS. Thank you very much. I should have asked. I make an assumption and maybe incorrectly that all of you have served in the military and I would love for you to each just share where you served and what branch.

Mr. HOGAN. All of us have served. I served in the U.S. Army and I served in Vietnam in the late 1960's.

Mr. SHAYS. Thank you for your service. Mr. Ingham.

Mr. INGHAM. Yes, I served in the U.S. Air Force. I was there during the Vietnam Era. I served in Germany and in the United States. I was activated for Desert Storm. Again, I served here in the States at Westover Air Force Base and I am currently in the Air Force Reserves as a Senior Master Sergeant. I have approximately 26 years and still going.

Mr. SHAYS. Sergeant, thank you for your service. Mr. Welsh.

Mr. WELSH. Twenty-four years in the Marine Corps, starting with Tet Offensive in Vietnam, finishing up with Desert Storm.

Mr. SHAYS. Thank you. Mr. Martineau.

Mr. MARTINEAU. I served from 1968 to 1972, U.S. Navy with 2 years in Vietnam.

Mr. SHAYS. Thank you, sir. Thank you all for your service.

[Applause.]

Mr. SHAYS. I am going to recognize Mr. Tierney, but I am going to ask you a question now that I would like you to just think about, if he is not asking you a direct question. And I would like you, I want to make the assumption that the clinics tend to be more user friendly and that they are a relatively new innovation of the VA that you are pleased with, but I would like to know if that is true.

I would like to know the best and the worse VA clinic and I would also like to know the best and the worse of the major facilities, what you think, so for instance, Mr. Martineau, I am going to force you to think of something really good about the major facility and we will get to it later. I will get the answers to my questions when Mr. Tierney is finished. Thank you.

Mr. Tierney.

Mr. TIERNEY. Thank you. As Irish as I look, part of me is French so I know for sure that it is Martineau on that and I hope, I see that you have so much to say and so little time to say it, it is always easy to speak for about an hour when you are passionate on an issue, but not quite as easy to speak for 5 minutes. So the next time you turn to C-SPAN you will see Chairman Shays and I struggling to get our thoughts in in 1 minute and you will know of the difficulty that is there.

Let me just say, Mr. Chairman, as I waive the deduction, you see four of our veterans' agents who I am proud to have in our District and work with and they are just an example of the great veterans' agent that we have in this District and that make our job that much easier and they represent the veterans so well. So I want to thank you publicly for the work that each of you do and for those that are in the audience that also work with us.

Jean-Guy, I know you are busy thinking of Chris' question, the chairman's question, but I do want to ask you, I know for a fact the amount of time that you spend on transportation, you personally, take any number of veterans where they have to go and Mr.

Ingham, I am going to ask you the same question because I know you do a lot of the same and I suspect that the others do also.

What can we do to improve the transportation situation between the veterans' homes and the clinics and the clinics and the hospitals in Jamaica Plain, in West Roxbury and in Bedford?

Mr. MARTINEAU. That is a very complicated question. Basically, it is almost impossible to really improve the immediate needs of transportation because the majority of the veterans that we transport to hospital, the reason why we do it is because they cannot take public transportation because they cannot even go to the clinics because they are either in wheelchairs or they have walking problems and they have to use walkers.

So we have to literally get them from their doorstep to the door of a parking lot over at the VA Clinic in Lynn and we do transportation, of course, as we told you at the Chelsea Soldiers' Home as well as the VA Clinic in Boston and the one in Bedford.

And again, many of these elderly veterans are World War II veterans and now Korean War veterans do have mobility problems. So to improve the transportation I think what you would have to do is guarantee funding for transportation that is more personal and more accessible to those veterans who cannot walk on their own. They cannot even get up from a wheelchair on their own without assistance.

So it is nice to have a car. It is even nicer to have a DAV van and I compliment the DAV. I can go on complimenting other organizations. However, unless you have someone who can physically assist the veteran out of his wheelchair or help him with his walker, he or she with his walker, it will not really make an immediate difference, but again, any support in funding that you can give on the short term and the long term directly to the cities and towns, veteran funding directly targeted at the clinics to provide transportation would be a definite assistance.

Mr. TIERNEY. Thank you.

Just by way of note I am going to talk to the chairman about this at some point in time and the committee members, probably trying to establish some sort of a pilot program, but I do not know just where we are going with it yet.

Mr. Ingham, maybe you can give us some suggestions too about what we might think of in terms of trying to get together an idea of how we go about this and also tell me if you would about Mass. Ride and whether or not positively impacts or gives you any assistance in this area?

Mr. INGHAM. One of the important issues is not so much as getting the vehicles. There are many organizations out there who are willing to donate vehicles. It is finding drivers. Volunteer drivers are very difficult to get. I deal with a lot of volunteer drivers for elderly transportation as well as for veterans and it is more a funding issue.

If you make it through either grants or through the government, really any kind of forms of funding where you make this affirmative position for driving is probably the largest improvement that you could do for help getting veterans into the hospitals.

As far as the outreach center, they looked for quite a while to get a volunteer driver. They had a van donated from the DAV, but

again, the most difficult part was finding a volunteer driver. So I think if there is any way that you could push for funding, through grants or whatever forms you can to get a permanent driver that would basically be the best solution.

Mr. TIERNEY. Thank you. Mr. Hogan and Mr. Welsh, I would like to talk to you a little bit about the communication aspect.

Mr. Hogan, you indicated that not every veteran is aware of his rights, what might be available to him or her within the health care, VA health care system. Can you tell us what you believe is the most used source of information by veterans, at least from your information?

Mr. HOGAN. I have most access in my community to the local newspaper, the local cable and I work very well with Mr. Conte and Mr. Bill Davis from the Bedford VA and for the chairman's information, my proximity to the Bedford VA is rather close, so I have a different perspective than the other gentleman.

I think if the VA and its representatives were to continue to do that, to work with the agents and the service organizations within the communities to have them disseminate the information, when I came on board as a veterans' agent, I was surprised at how little so many of the veterans knew about what was available to them through the VA. So I think the VA by itself putting out a newsletter on a Website is one thing, but I think they have to network just as well with the agents and the service offices within the communities.

Mr. TIERNEY. What sort of information you get as veterans agents when you are dealing with the Veterans' Administration?

Mr. WELSH. You mean—

Mr. TIERNEY. The Veterans' Administration, how do they communicate with you and how often do you meet with representatives, how often do you get either e-mails—

Mr. WELSH. The Website is a good source. There is also a book, we call our bible so to speak. It is "What Every Veteran Should Know." I use the 800 number a lot. There is no problem with communication between an office like mine or the other veterans' offices across Massachusetts. Massachusetts is unique with this veterans' benefits, the agents that we are.

I think there is only one or two other States that have the same system, so the veterans in our communities can come to our office and ask any question whether it is a State-related question or Federal VA and we have all sorts of way to get this information, as I mentioned, not only by the literature that is put out, the Website, but also the regional number and I have had no problem in getting good feedback from the VA system and in particular, the health care system.

I want to make a little pitch here in case I am not asked about the Bedford system. I think they are super. They provide a great service and I know the veterans from Gloucester, at least the majority of them and have never had one complaint about the VA system in Bedford.

Mr. TIERNEY. While I have you at the mic, I know that you believe strongly in traditional clinics, community based outreach clinics. Could you take just a moment to put on the record what that would mean to the average Gloucester veteran resident?

Mr. WELSH. A lot. As I mentioned there are so many veterans in Gloucester and particularly from the World War II area, many on oxygen. There is no transportation system to the other facilities, something that I know your office and I will be working on. And particularly for those World War II veterans, just to be able to go down the street to a clinic if we had one in Gloucester, I would be happy to go pick them up at their door and take them because it is just so difficult for them to get out. We have facilities in Gloucester and I know again for the older veterans it would just be a tremendous thing.

And even the younger veterans, many of them do not have the ability to drive. They have problems that keep from even taking public transportation, but particularly for the older veteran it would be a tremendous thing.

Mr. TIERNEY. Thank you very much for that. Let me just ask one last question, Mr. Ingham. I am gratified that so many veterans find the community clinics helpful as you indicated, but in the course of your testimony described as key to the earlier detection and prevention as well as life saving capabilities, things that have talked about, do you have a specific example in mind when you mentioned those issues?

Mr. INGHAM. I have a specific case. An individual came into my office. He was having a hard time in trying to get health insurance and he came and asked me how could I help him out and that was right when we started the clinic, he was probably one of the first ones to get in. He was the individual I was talking about that had the heart condition. So he went in, got into the system, saw Dr. Balse, was found to have a heart condition, went through the VA system, was treated and still comes in to see me regularly.

We did have another individual, Walter Hamal, who is our last World War I veteran. He was also one of the first into the clinic, as our first customer, basically. Unfortunately, he just passed away, but he did take quite advantage of the system and was very happy for it.

I want to bring up one point brought up earlier by Congressman Tierney, two, possibly three. I think it is because of his commitment and a stronger point was education. We throughout the veterans organizations in Haverhill, we all as veterans' councils, came together very closely as a unit to get the clinic into Haverhill and because I think of that we are able to get more education out there and there was more information brought into the community. So that is a big reason that we do have the clinic.

Mr. TIERNEY. Well, you lobbied it last night, the staff tried to get me lost in Boston, trying to explain how difficult it is to get into Boston from here, so it never ends. They work on everyone.

One last question. This is just a curiosity question, Mr. Welsh. I want to know if it is ever been determined why we have the higher concentration of veterans in Gloucester?

Mr. WELSH. Fishermen. Many of them are natives.

Mr. TIERNEY. Last, let me just reiterate as some of our witnesses have said before, we have an excellent homeless shelter here and Tom Lyons is in the audience and does a great deal of work with that. We have spent a lot of attention in Congress trying to deal with special veterans' issues, that is one of them, obviously and I

just want to add my commendations to Tom and people who work with him for the great work they do.

Mr. SHAYS. I hope he will address the committee so we will have him on record as well.

Mr. TIERNEY. Thank you, Mr. Chairman. Thank you, witnesses.

Mr. SHAYS. I am wanting to know the best and worse of both the clinics and the primary VA facilities. And Mr. Hogan, I will start with you.

Mr. HOGAN. The best part of it, I think, is the care, once you get into the door.

Mr. SHAYS. Which facility?

Mr. HOGAN. I am with the Edith Nourse Rogers, again, I am the director which is next door to Bedford.

Mr. SHAYS. So you do not really utilize the clinics?

Mr. HOGAN. No. But the care in the facility, I think, is wonderful once you get through the door. The worse part sometimes is beds, there is not enough time and with the aging population, an awful lot more people with education are trying to use the facility, so I think sometimes the weight could be the worse part, but I think the care, once we get through the door is the best Bedford has to offer.

Mr. SHAYS. Mr. Ingham.

Mr. INGHAM. I think the best of the care dealing with the CBOC. A comment was made that their staff should be commended, Dr. Balze, the nurses, nurse practitioners, everybody there is just excellent and willing to work with the veterans. It has been a unique experience to start just developing the clinic and where we went with that and getting the organizations together with a letter of writing and calling of Congress and everything.

But the work of the facility, like the Bedford VA is so advanced to look ahead into the future as Mr. Conte did, we started out with really nothing and got health care into Haverhill. It is just an amazing event.

Mr. SHAYS. What about the larger facilities?

Mr. INGHAM. I think the problem with the larger facilities is transportation, getting into them. A lot of the older veterans, especially, are intimidated trying to take the services to get in there. And I think our future too with the geriatric type situations. We were just told as agents at our last meeting that there is a high rate of Alzheimer's with veterans and they do not really know why. It seems that in the general population that veterans——

Mr. SHAYS. What would be the best that you would see in the larger facilities?

Mr. INGHAM. Probably just the overall care. They can handle anything from cardiac, heart conditions, all type of care. It is there, it is available and it is a shame that many are not taking use of it.

Mr. SHAYS. Mr. Welsh.

Mr. WELSH. As I have already mentioned I believe the Bedford Medical Center is the best in the area. I am not very familiar with Haverhill because people do not go from Gloucester to Haverhill, but those that have gone to the Lynn outpatient clinic seem to be satisfied. The worse is the clinic on Causeway Street in Boston, that is my——

Mr. SHAYS. So your point rather than saying what is the best or the worse of the clinics, you are actually saying which clinic you think needs the most improvement?

Mr. WELSH. Yes sir.

Mr. SHAYS. Let me just quickly, why do you think that needs the most improvement? Just in terms of the interaction or parking or what, the facility itself?

Mr. WELSH. When we talk about the outpatient clinic?

Mr. SHAYS. Yes.

Mr. WELSH. In Lynn, there is no problem with parking. You cannot get to Lynn from Gloucester. It is one of those tough things, but there is adequate parking. I think the people are very courteous and that is why I do not have many complaints about the Lynn outpatient clinic. Causeway is a big problem because there is no parking and there seems to be a different attitude at the Causeway—

Mr. SHAYS. Do they have more queuing up there? Is it more like the traditional motor vehicle department?

Mr. WELSH. I think there is more of a downsizing of Causeway. Someone else could answer it better than me, but it seems as though it is going away.

Mr. SHAYS. OK, Mr. Martineau.

Mr. MARTINEAU. Mr. Chairman, I am not here to throw hand grenades, maybe a few rocks and pebbles, but not hand grenades.

Mr. SHAYS. He says that because he is a veteran not only of the service, but a veteran of the city council and they know how to do this. [Laughter.]

Mr. MARTINEAU. I am a good Republican, Mr. Chairman. [Laughter.]

Mr. SHAYS. I want to give you special time. I have not met a Republican in Massachusetts, so this is—[laughter.]

Mr. MARTINEAU. I knew we had something in common, Mr. Chairman. You know, I just want to preface my remarks by saying that I find my responsibility with the veteran initially is to give him the best first visit he can get at a VA health care facility.

This is why I personally take that veteran to the hospital, clinic myself, so I know what I am talking about. I do this almost on a daily basis. So I had some initial problems with the Lynn clinic as the Congressman knows, and his staff. He is got a fantastic staff. And they have ironed those problems out.

The good part about the Lynn clinic is many of our veterans will go there on their own. It is a short ride today and it lessens their transportation time. The bad part about the Lynn Clinic is many of the veterans will travel to the Lynn Clinic and then will find that they will have to leave the Lynn Clinic, take a shuttle and go to Bedford or JP for testing.

Mr. SHAYS. So these are services they are not really going to get?

Mr. MARTINEAU. And I will be at Bedford or I will be at Jamaica Plain and once I get there and transport my veterans there, some of the veterans will recognize me who are on a shuttle from Lynn, will ask me to take them home from Bedford and take them back to Lynn because it is really on our way back to Salem.

So as far as the Lynn Clinic goes, my hats off to the decision-makers to go that route. I think the neighborhood clinics as Lynn

and elsewhere are very important because generally speaking it does save time in the veterans' traveling day.

Mr. SHAYS. How about the primary major facilities? What is the best and the worse?

Mr. MARTINEAU. I can speak for a long time on Bedford and Jamaica Plain and the Causeway Street clinic, but let me just generalize, because—I do not understand communication between Bedford and Boston. There is none. I have had one veteran as recently as a couple of months ago who had been treated in the JP Clinic in Boston, the Jamaica Plain for years and it took him 4 hours administratively eligible for medical care in Bedford, 4 hours. So here is a guy that had VA health care in Boston and going to Bedford he had to be re-enrolled all over again.

Mr. SHAYS. Fair enough, so communication—

Mr. MARTINEAU. Computer hookup, Mr. Chairman.

Mr. SHAYS. And common sense.

Mr. MARTINEAU. Yes, there is no—I do not know what the computer hookup is, but as far as I can see, there is not any.

The other problem that I have experienced is going in with the veterans, the doctors are not experienced for the most part. You have too many foreign doctors and you have too many doctors that are really not experienced. They are students who are practicing medicine on our veterans and I do not think that is right.

Mr. SHAYS. OK.

Mr. MARTINEAU. Insofar as the administrative staffs, I think that now too many of our administrators, health care providers, social workers and patient representatives are doing two and three jobs and I do not think—it is because of the downsizing effect and I think that is a drawback.

Let me just say some good comments that I would like to make about Bedford and Jamaica Plain. Accessibility to the administrators and the social workers in these hospitals is excellent. I have never been refused on a moment's basis. They have always taken time from their day. I do not know if it is because I will go to their bosses.

Mr. SHAYS. But it is a very important positive and it is nice that you are expressing that. So access is there and that is great to hear.

Mr. MARTINEAU. Also Bedford provides terrific adult day care and especially their branch office over at the Chelsea Soldiers Home. I think that could be expanded, but I congratulate Bedford for their adult day care and the services that they provide with their staff at the Chelsea Soldiers Home, that is really great. But you know what is really fantastic about both Bedford and Jamaica Plain and that is their detox.

A lot of homeless veterans can get detox in Bedford and Jamaica Plain and when you take them they immediately get the care that they need.

They have teams of people that surround themselves with these veterans and take care of their emotional needs, their physical needs, their rehabilitation needs, getting them back on their feet, both personally, professionally, medically and also followup. So as far as detox goes in Bedford and Jamaica Plain. They are the best. So that is about it.

Mr. SHAYS. Thank you very much. I have some questions that I would just love to get on the record. I am going to look for shorter answers because I do want to hear from the veterans that are going to speak. By the way, I would invite you all to stay up there if you like while the veterans are making comments and if it is not abused invite you to make short comment periodically about what you have heard, if you would like.

I would like to first ask have you noticed an increase in veterans taking part in the VA health care system? If the answer is yes, why do you think this is the case? If no, what can be done to encourage veterans. I not looking for long answers, but are you seeing the increase and then respond why you think your answer is what it is.

We will go with you, Mr. Martineau, first since you have the mic.

Mr. MARTINEAU. As it has been stated by my fellow veterans' advocates up here, we have definitely seen an increase in people going to the VA because of the downsizing of the HMOs and the downsizing of their private health services.

Mr. SHAYS. OK, the reason I am having trouble with a French name is because I am married to a French woman named Deraïne so there is no excuse.

Yes?

Mr. WELSH. Definitely an increase in veterans signing up because we have had some great health fairs, thanks to Congressman Tierney's office. Also, our veterans' services organizations in Gloucester, AMVETS, VFW, American Legion, they have gotten the word out, so communication, publicity, we have newspaper articles from time to time, veterans say I can sign up and they do.

Mr. SHAYS. I know Mr. Martineau was responding, nodding the head as you made that point too, so Mr. Ingham?

Mr. INGHAM. Yes, definitely, the CBOC in Haverhill is seeing an increase close to approximately 50 a month. I said 1,200 over the year. I think most of it is due to education and the biggest is on word of mouth. Veterans talk to veterans. That is one of the biggest ways of getting it around.

Mr. SHAYS. Mr. Hogan.

Mr. HOGAN. I agree also. I think there is an increase of use going on right now. A lot of it has to do with the publicity that we are able to get out through veterans' newsletters, newspaper articles. Once the veterans realize that they are eligible now and I think one of the big issues right now is that there is a pharmacy use and the hospitals because of the explosion of co-payments and insurance problems with medications and pharmaceuticals, they are going to the VA and they are signing up.

Mr. SHAYS. Let me do this, let me—if you do not mind staying up there you are welcome if you have to leave for a second and want to come back. We will invite from our audience anyone who wants to make some comments and this is how it is going to work.

I am going to ask, Karen, I am going to ask you to get their name and address on a file card after they have spoken so we can get the transcriber the exact spelling of your name. We are going to want to know if you served, where you served, what branch you served in and where you served. We can use the portable mic if that works.

Jason, you have the mic. Let us do that.

Mr. TIERNEY. Mr. Chairman, just 1 second. I think it should be noted for those that might not already know it, several of the veterans service organizations have representatives here, but they have also been invited by the chairman to submit for the record. We would like to have that and it will all be entered on the record.

Mr. SHAYS. It will all be entered into the record. So sir, I see you are standing up and we will invite you on that side.

Let me ask you, are there mics on both—we do not need the portable mic—do the mics work that are there? Can you turn the floor mics on to see if they are—would you see if that one works? Just speak into it a second. Yes, both of them work, so we will use that, Jason, so we do not need you to hold the mic there, but Karen, when they are done, get the full name and address so we will be able to have it on the record.

OK, and if you would state your name, if you served, the branch of service and where you served.

Sgt. BRYAN. My name is Staff Sergeant Edward J. Bryan. I am still active in the Massachusetts National Guard. I joined the service in 1974, U.S. Army.

Mr. SHAYS. Let me say this. I am going to do 2 minutes a statement. Is that all right?

Sgt. BRYAN. Yes. I only have a few basic questions, they are kind of loaded ones, but I am not throwing hand grenades.

Mr. SHAYS. You have got a lot of pages, that is why I am concerned.

Sgt. BRYAN. I already submitted them for the record.

Mr. SHAYS. OK, sir, again your name.

Sgt. BRYAN. Edward J. Bryan.

Mr. SHAYS. Mr. Bryan, thank you.

Sgt. BRYAN. I served with the 1173rd Transportation Terminal Unit in Boston. Went to Saudi Arabia. I am now retired from the fire department because of my Gulf war service and I am disabled from the National Guard from my Gulf war service.

I have a couple of questions. I know you are here, there is a \$1 million plus a day that you are worried about from the GAO, you stated that in your statement. I know it is a problem with the U.S. Government and going to combat like World War II veterans, Vietnam veterans, Korea, Gulf war and other conflicts, I think the budget should be either level funded or increased. I got an increase of \$25 billion in the statement that I submitted. The reason why is because we just had a conference in Washington on April 5th and the next hall over was asking for \$600 billion for infectious diseases. That is a concern.

The first question I wanted to ask today was on the program up here in Bedford. Are the biopsies sent to the Armed Forces Institute of Pathology? Now how are we going to get to the bottom of Alzheimer's Disease if nobody is recording it? I found that out at Walter Reed Institute last summer. I am doing research on Alzheimer's itself because there is an interaction between Gulf war veterans, Vietnam veterans and ADD people.

Question No. 2, Persian Gulf war appointments are not being done in Massachusetts. They are not being followed, according to Public Law 103-446. I got a letter from Colorado with a gentleman

having problems. We are seeing this all across the Nation. This is a national problem.

I am a member of Merrimack Committee here, VISN 1 and we are trying to address that problem with a basic test versus a full screen test. We are trying to get that through all the way to VISN 1 and all the way to the Network Director, Mr. Clark, I think it is.

Mrs. Murphy stated on HIV and hepatitis C, but she did not mention leishomeniosis or other infectious diseases. Whatever the cost—

Mr. SHAYS. Mr. Bryan, I am going to interrupt you a second. I am just going to have—we do not have so many people here that I maybe can adjust the time. We are going to try to get out of here by 1:15 at the latest and I would like to just ask how many people would like to speak and then I am going to—keep your hands up nice and tall. I am going to be real strict then.

I am going to say 3 minutes at most and the questions are going to be rhetorical in the sense that we are going to have them in the record and then we are going to try to get some answers for them and we will make the answers part of the record as well. OK, is that something we can do.

So yes, you have about a minute left and thank you.

Sgt. BRYAN. Because I found out that doctors are not doing the tests because the VA, thanks to the VA in Washington put out these big booklets that all of the doctors are supposed to review, but they are only reviewing the little booklet and they are doing the tests. They have to look at the whole spectrum. So that is a big national problem.

A lot of the times you will look back at these suffering Gulf war veterans and Public Law 103-346 is not fully enforced and I think that is a key question, enforcement of it. I got that in the documentation and I want to—I know there are State issues here also, but there are major problems. You are going to be hearing from me and a few other Gulf war veterans throughout the Nation, your committee, within the next several months to another year because we need much more treatment trials and the two treatment trials that are out in the VA are not very promising.

We need at least 10 more before September and I want to be trying to work with Dr. Pughsner. I am having troubles, but it is an IG complaint, but I want to see if I can step through your committee to get that accomplished.

Thank you.

Mr. SHAYS. I would be happy to have you work through our committee. I will invite you all, just take notes and at the end when they are done I will invite just brief comments from all of you on any comments you want to say that you have heard. Thank you, Mr. Bryan.

Sgt. BRYAN. Thank you, Congressman Shays for sticking your neck out. Thank you.

Mr. SHAYS. Thank you, sir. Sir?

Mr. HART. Good afternoon, sir. Mr. Chairman, Congressman Tierney, my name is Terry Hart. I am the veterans' service agent, director of Veterans' Service from Ipswich.

Mr. SHAYS. Excuse me, I am just going to interrupt you just a second. Karen, are you doing it? I want to make sure that the names are totally verified with the individual after you get them. OK, thanks. I am sorry, sir.

Mr. HART. No problem, sir. Seeing as the veterans' agents up here represent the Army, Air Force, Marine Corps and Navy, I wanted to let you know that I represent that fifth service, having spent 27 years in the U.S. Coast Guard.

Mr. SHAYS. Yes sir. As did my brother.

Mr. HART. I am adjacent, my area, four towns, adjacent to Gloucester, the towns of Ipswich, Essex, Hamilton and Wedham and I have been using the clinic at Haverhill significantly in the last year that I have been a veterans' agent, sending people there right, left, up and down. Would also very strongly support the concept of a clinic at Gloucester.

I have a lot of people who drive very little and being stuck in the middle there between major cities of Gloucester and Haverhill, major for our area anyway, we have some of our senior veterans who will go to Haverhill, will not go to Gloucester. Others who will go to Gloucester, will not go to Haverhill. So we like the idea of having a clinic in Gloucester as well.

I would also like to make a couple of comments with respect to what has gone on this morning. Dr. Post indicated that there will be an increase probably in the cost of co-pays for pharmaceuticals through the VA clinic. I would like to go on record as stating that I hope (a) we can extend that then to a 90-day prescription in terms of the co-pay cost because I think that is a logical extension.

Right now, it is \$2 per 30-day supply per prescription. If somebody can get a 90-day supply for whatever the co-pay goes up to, I think that would be a logical way of doing it since you said the cost is based on the administrative costs.

By the same token, you should know that that is one of the key drawing cards for us to send people to your clinics is the idea that those costs to pharmaceuticals going down is a big factor in people wanting to use the VA clinics. I would also like to praise Mr. Conte. As a member of the Northeast Veterans' Service Officers Association we met at Bedford a month or so ago and the suggestion was made by me that they ought to have some of us on their board of advisors. Mr. Conte now has four of us, including myself on his board of advisors for Bedford VA and I think that improves the communication tremendously in our area.

And communication is the key. What we find, of course, is many service organizations represented here, each of them have members. They have their own newsletters. We all go through the newspapers to try to get our word out to people. The Department of Veterans' Services provides word as well as they can, but until we get some sort of linkage in communication. We are still not reaching all the veterans and that is a key part of what we are doing, sir.

Mr. SHAYS. Thank you very much.

Mr. CALLANAN. Good morning. My name is Dan Callanan. I was born in 1924, joined the Marines on my 18th birthday. Three years later I was lucky enough to come back from the Pacific without a scratch on me. I was told that the Veterans' Administration was for people with disabilities. I did not know anything about anything to

the contrary, but I visited many of my old mates at VA hospitals, people without arms and legs, people I had known, people I got to know.

Recently, thanks to you people in Congress, you have passed a law which provides prescription drugs and I came out here today to thank you for that and to leave with you a bunch of eyedrops which cost me a small fortune in the past year and a half.

I say a small fortune, but I had a detached retina. I do not know what caused it. It happened in August a year ago while I was mowing my lawn. I thought it was just another fleck of dust that comes out of this power plant in Salem which is soot all over the neighborhood, but maybe it was a bee that bit me, but before the day was over a retina surgeon at the Lynn Clinic told me it was detached retina. I went almost a whole year without being able to read a newspaper, spending a lot of money on eyedrops. Now I am getting them for \$2 each. According to the letter that I received last week, it is on file here. Thank you for this opportunity.

Mr. SHAYS. Thank you very much.

Mr. CASCELLA. My name is Craig Cascella. I am a retired sergeant in the Marine Corps. I served as a Military Police Officer in Quantico, VA and I was also stationed in Washington, DC. I served as Presidential Security Guard. Mr. Chair and members of the committee—

Mr. SHAYS. You know what, we have a problem. And that is we need to get you on tape. So I am going to let you start over again? We will insert the written statement in the record then. The reason I said that this is not just an exercise in futility. We actually transfer this transcript. Then the staff studies it. Then we make recommendations and so this is not idle chatter that you are participating in. This is a congressional hearing in which what you say we hope to have some impact in what happens in government.

Let me just do this. I am going to have, I am going to see if we can solve the problem of you being on the mic and I am going to just interrupt. I am going to have someone else speak and let me, see, Karen, you put your head together and think how we can do that. If you do not mind, I am just going to have you wait a sec and have this gentleman speak.

Are you going to be here later, sir? Will you be here for a while?

Mr. CASCELLA. Yes.

Mr. SHAYS. OK, let us see if we can solve the problem getting you on the transcript. Yes sir?

Mr. BOWERS. Thank you, Mr. Chairman and Congressman Tierney. I am Alan Bowers, third national junior vice commander of the Disabled American Veterans [DAV]. I was medically retired from the Air Force in 1974 after I injured my spine when I ejected from an aircraft in Vietnam. I am here to present the views of the nearly 45,000 members of the DAV and auxiliary who reside in Massachusetts.

We have submitted to you, sir, a written text and we respectfully request that that text become part of the record.

Mr. SHAYS. That will be part of the record.

Mr. BOWERS. Thank you, sir, and I will just make a couple of quick comments to highlight a couple of points.

Since 1985, the buying power of VA medical care appropriations has fallen because of inflation. The total 2000 VA medical care appropriation is worth only 82 percent of the 1985 appropriation. That decreased buying power has adversely affected the Department's ability to provide safe, quality assured care.

In 1996, VISN 1 had \$856 million. In 2000, it has \$867 million. That equates to a 1.21 percent increase in allocations and MCCC receipts over 5 years. I note from a fax that I received from the National Office of the DAV Friday afternoon that on April 7th in the morning, the Senate passed the Johnson amendment which would add \$500 million to President Clinton's proposed \$1.4 billion increase. That is completely in line with what the DAV independent budget requests and we would hope that the House would go along with that effort and match that effort. It would go a long way to helping the VA have the dollars they need to give quality care.

With respect to the hepatitis C, Dr. Murphy mentioned the 1-day test sample where approximately 6.6 percent of the veterans tested came up positive for the virus. Under VERA, veterans who have the virus are considered basic care patients. As I understand it, that means that the VA or the VISN gets \$3,249 a year for that patient. We suggest that a health care diagnosis should be reimbursed at the rate of a complex patient.

One of the individuals testifying this morning mentioned high staff ratios in VISN 1. But in fact, the DAV has heard testimonials from frustrated and demoralized health care providers, including physicians and nurses, when they are working with sicker patients and they are working longer shifts or perhaps even double shifts, both the patient and the provider are at risk. So we ask you to take a very hard look at the staffing levels and make sure that they are adequately staffed so that there is quality care and there are no medical errors.

Mr. SHAYS. I am going to extend your time a little bit here. How much longer do you need?

Mr. BOWERS. One final comment. I just want to say thank you. The Disabled American Veterans has one purpose, to build better lives for disabled veterans and their families. We rely on you and the VA to help us provide safe care, adequate care, accessible care. The DAV pledges to work with you and I am confident that together we can build better lives for the individuals who fought for America's freedoms.

Thank you very much.

Mr. SHAYS. Thank you for your service. It is wonderful to have you up front so I can see your smiling face in the light.

Mr. CASCELLA. It is great to be down here.

Mr. SHAYS. Is this mic on now?

Mr. CASCELLA. Do you want me to start with my intro again or do you know who I am?

Mr. SHAYS. Yes, I want you to start all over again. Thank you for your cooperation.

Mr. CASCELLA. It is no problem, Mr. Chairman. My name is Craig Cascella. I am a retired military—from the Marine Corps. I was a sergeant from 1988 to 1992, stationed in Quantico, VA and also in our Nation's Capital, Washington, DC. I was a military po-

lice officer and also served as a Presidential security guard for Presidents Reagan and Bush, respectively.

I am currently the secretary of the New England Chapter of the Paralyzed Veterans. On behalf of our members, I would like to thank you, Mr. Chairman, and members of the committee, for holding this hearing in our area and allowing us to provide this statement.

I have submitted copies of my written statement and I hope that they have been distributed to you. If not, I would be more than happy to give you another one.

First, I would like to comment on the fiscal year 2001 VA budget that was submitted by the administration. For the first time in many years, a reasonable increase has been proposed for veterans health care. The \$1.5 billion total increase including the \$1.355 billion for health care is a good and welcome beginning, although it is less than the \$1.9 billion increase that is recommended by PVA.

It is our understanding that the \$1.9 billion increase is more in line with what the VA requested to pay for all existing and new programs. The PVA recommendation is based on careful analysis of present and future health care trends and includes the costs of the new initiatives such as emergency care, hepatitis C and long term care provisions called for in the Veterans Millennium Health Care and Benefits Act.

The PVA has recommended a \$20.66 billion appropriation for medical care. This amount represents a \$1.8 billion increase over the amount provided in fiscal year 2000. The PVA has recommended a \$386 million appropriation for medical and prosthetic research. This represents a \$65 million increase over the administration's flat line request. The PVA recommends a \$71 million appropriation for the medical administration and miscellaneous operating expenses account. This represents a \$6 million increase over the administration's request.

In total, the PVA has recommended a total increase for Veterans' Health Administration of \$1.9 billion, \$555 million over the administration's requests which includes nearly a \$1 billion increase just to meet the routine escalating costs such as salary increases and inflation.

Mr. Chairman and members of the committee, we ask that you support the recommendations of PVA. We also ask for your assistance to insure that the VA receives the funding that it needs to insure that veterans who rely upon the VA for their health care needs are accorded adequate and quality health care.

Let us work together, building upon the accomplishments of last year to secure for a solid budget base for health care in the years ahead.

We ask you to reaffirm our Nation's covenant to veterans and to remain faithful with generations of promises.

Last, I would like to comment on a local issue.

Mr. SHAYS. If you could just bring it to a conclusion.

Mr. CASCELLA. Yes, Mr. Chairman. Analysis showed that millions of dollars could be saved if the West Roxbury at Boston VA Medical Centers were consolidated. In order to complete a successful consolidation, some construction and renovations were needed at approximately a cost of \$30 million. At first it was thought the

VA Central Office would provide all funds needed for construction and renovations. That thinking proved to be wrong.

The VISN will have to provide the funding for the entire consolidation. We have learned that in order to fund the cost of construction and renovations, the VISN will have to use all of their minor construction funds and equipment purchasing funds for the next 3 years. We believe that this is the wrong way to fund the consolidation.

Overall, quality of health care provided and quality of care in not purchasing replacement equipment or new equipment will be sacrificed. We believe that the VA Central Office must provide the necessary funds to complete the consolidation.

Mr. Chairman and members of the committee, we ask that you look into this matter and encourage the VA Central Office to provide the necessary funding to complete the consolidation that will eventually save significant resources.

Mr. Chairman, that concludes my statement. Again, I thank you for coming to our area and allowing us to present our comments to you all. Thank you.

Mr. SHAYS. Thank you. And I appreciate you being flexible with us in coming up front like this so we could record your statement.

Mr. CASCELLA. Thank you for being flexible.

Mr. SHAYS. Thank you. Who would like to speak at this moment?

Ms. MAGUIRE. My name is Hilary Maguire representing the Veterans Northeast Outreach Center in Haverhill, MA. I also served on the 782nd Maintenance Battalion under the 82nd Airborne Division during Desert Storm.

Just for a real quick note to clarify, our van was donated by the VFW of Massachusetts and also Congressman Tierney, just so you know in regards to your question about 214s. There is a number in Boston. It needs some revamping, but it is another option for those that live in Massachusetts trying to get their 214s.

My question today and I hope at some point there will be some clarification, I have had several women come into my outreach center who suffered from sexual trauma while on active duty. I have read the law. It is my understanding that they are eligible for sexual trauma counseling, but I do not know if it needs to be clarified or if they are eligible for health care benefits.

Two women have come into my center and have been denied benefits due to their time while on active duty. It is my understanding that they need to serve a minimum of 2 years. I am hoping that maybe this could be addressed and the 2-year eligibility requirement dropped.

Mr. SHAYS. If they have served less than 2 years, they are not entitled to benefits?

Ms. MAGUIRE. Yes, that is the answer that they have been given.

Mr. SHAYS. I am seeing a shaking of the head of someone who is in a position to know, so let us say this. We will get the answer and hopefully respond to it to you before we leave today.

Ms. MAGUIRE. Thank you.

Mr. SHAYS. Thank you. Will you make sure that happens, please?

Mr. DALEY. Good morning, Congressmen, Tom Daley, State Adjutant for the DAV. And I just want to say on that DD 214, Congressman, in Massachusetts, anybody who has received a bonus in

Massachusetts going all the way back to the first World War, the Department of the Adjutant General's Office will have a copy of that discharge.

Mr. SHAYS. Thank you.

Mr. DALEY. And also I would like to present this written testimony concerning the hepatitis C, Gulf war veterans compensation and DIC entitlement which I will—

Mr. SHAYS. Excuse me, 1 second. Do we have a tape problem here? No problem. We will take care of it. We want it on the record. I have to tell you this is my most favorite part of the hearing.

Mr. DALEY. I will be submitting written testimony on long term care, hepatitis C, Gulf war and veterans issues and conversations with DIC, means testing, etc.

I just want to say we have good working relationship with the veterans agents in Massachusetts. They are very supportive of us and we work together on case loads. Dan Stack, a supervisor here for the DAV National Service Office, so we do work together.

Roughly 15 of the 20 percent of the veterans across this country belong to veterans organizations and the rest of the veterans do not even know what is going on in this country. That is the problem.

In Massachusetts, to be a veteran in Massachusetts, you have to have 1 day wartime, 90 day service. We have a lot of veterans in—I know that is not a Federal issue, but it is important to us because we are trying to get legislation passed in Massachusetts to pick up all what we call old war veterans and we want to make sure that they are included in the benefits across the Commonwealth because that will enhance, that will bring in issues, that will bring more people and more penetration into the VA system. We are trying to work on that now.

So again, concerning the veterans issues in the Commonwealth. On that 90-day, 1 day wartime, they are not entitled to benefits because they are not entitled to real estate exemptions. They are not entitled to Chapter 115 benefits administered out of the Department of Veterans Affairs and they are not entitled to Civil Service preference.

But my own opinion is if anybody who puts the uniform on in this country is entitled to benefits, so I would like to see that happen. We are working on it in Massachusetts, the DAV and all the veterans organizations to pick up all the old war veterans and I am sure that it will help the VA long term care down there, more veterans penetrating the system into the VA health care system.

That is all I have to say, thank you very much.

Mr. SHAYS. Thank you very much.

Mr. BOUTIN. Mr. Chairman, Congressman Tierney, my name is Gerard Boutin. I am Commandant for the Marine Corps League for the Department of Massachusetts and I have two very quick questions. The first concerns the screening for the establishment of the Lynn Clinic which I think is a great thing.

At that time they were looking for members to sign up so they could have a large member on their rolls. I just recently have been re-enrolled and one of the things that they state is what if I am sick when I am traveling. It says you may receive health care at any VA health care facility in the country, well, that is really not true.

Recently, I was in Florida last February and I noticed a sign for a VA clinic so I went in and I presented my card and said if I needed medical assistance could I come into the clinic and their answer was no. You are not in the system. And they proceeding then to give me a whole bunch of paperwork that I would have to fill out and which I brought home.

Shortly thereafter, I went over to St. Petersburg and had to take a blinded veteran to the VA hospital and I did the same thing. I asked if I had to take care of any medical problems and I presented my card again, I said could I come to this facility and the answer again was no. You are not in the system.

So I really do not understand if we are in the VA and we are not in the system, as I understand in asking questions when I get back, we are here in the system in Wheaton and that is about it, but it does not take care of when we travel and I think a lot of the veterans, that is what they need. We will look for the benefit if we are traveling.

Second, I am receiving bills from the VA because the VA cannot bill Medicare for services and maybe you know all about that and I would like to bring that up as a point. The VA, as I understand cannot bill Medicare for services. Therefore, any services that I get in the VA hospital in Bedford, I have to pay out of my own pocket.

Mr. SHAYS. I was under the impression that services were available wherever you are and so I would like to nail that one down and maybe that can be dialogued before we leave directly with Dr. Murphy or our other two panelists who were there.

Mr. BOUTIN. Incidentally, you asked, I was in the Marine Corps from 1946 to 1952. I served as a Staff Sergeant with the 2nd Marine Division.

Mr. SHAYS. Thank you for your service, sir. Yes sir?

Mr. BECKER. My name is Bernard Becker. I am a past State commander and past regional commander of Jewish War Veterans. I served in the Air Force from 1950 to 1954. VISN 1 as far as I am concerned stinks. We are closing up wards at hospitals. We are closing buildings at Brockton VA and then people who have the Alzheimer's cannot find a place to go. They are told by their families, take them to a private place and they will take care of them.

As far as I am concerned they should keep these buildings open, keep the wards open and take care of the veterans in the facilities. Holyoke, Chelsea Soldiers Home, there are waiting lists. They cannot put any more in there, but when they are closing up these buildings, I cannot see why they cannot keep them open and put the veterans in those buildings and I also have from my national organization, they did send me a fax on veterans issues.

Mr. SHAYS. Thank you.

Mr. CALOMO. Thank you for letting me speak today. I am a past Vietnam combat medic and I served in the Army in the 199th. I am from Gloucester, MA and I support Colonel Welsh, a veterans' agent, because of the veterans, I am the past city council of Gloucester, and many—

Mr. SHAYS. You are not a Republican?

Mr. CALOMO. No, I am a Democrat. [Laughter.]

I am sorry, I am a Democrat. I have had many veterans also call me and tell me they cannot get transportation to Bedford or Boston

and I myself go to Bedford and Boston. I go to Jamaica Plain and I have a lot of trouble driving into Boston, so I do not do that. I take the train and I spend the whole day trying to get to my appointment and get back to Gloucester.

Also a lot of the veterans cannot get a ride from Boston to Bedford. They have tried. A lot of time the drivers are unavailable through the DAV. They do have vans, but a lot of times the drivers are unavailable. So it is hard to meet scheduled appointments.

I also work for a home health service and I have had clients that ask me to take them and I have done that. So at this point I reemphasize a real need for us to have something in Gloucester, a medical facility.

Thank you very much.

Mr. SHAYS. Can you say your name into the mic?

Mr. CALOMO. Samuel Calomo. Thank you.

Mr. SHAYS. Thank you, sir.

Mr. GONZALEZ. Good morning, Mr. Chairman and Congressman Tierney. My name is Salvatore Gonzalez and I am from Chapter 3240, the name of it is General John S. Patton, Jr. from Beverly and I am here to request information from you, if I may.

We have a member of our chapter who has been very sick and lives on the second floor and he needs assistance because he cannot negotiate the stairs. He has to sit down two to three times before he can out to the second floor.

I went to make an initial contact in Jamaica Plain about what we could do to help him out as far as getting an electric chair. The doctor had to recommend then to the Rehab Medicine in the fourth floor so that they could approve the recommendation before he could be eligible to receive an electric chair. By the way, this veteran is 50 percent service connected for the Second World War.

I made the initial contact in March and the closest I could get a doctor to see him at the VA, it is May 17th, so the guy is still trying to get off the second floor which is very hard for him.

My question is this, what does a person like that have to do when he has to go out and get help? Where does he go from here?

Mr. SHAYS. We are not going to take any questions right now, but we are going to have your question on the record and we have staff here that can respond to the question.

Mr. GONZALEZ. Thank you, sir.

Mr. SHAYS. Thank you.

STATEMENT OF NEIL F. RESTANI, DIRECTOR OF VETERANS SERVICES, TOWN OF LYNNFIELD

Mr. RESTANI. Mr. Chairman, my name is Neil Restani. I am the director of Veterans Services for the town of Lynnfield. I have a statement that I would like to read. Also, I served from 1942 to 1946.

Regarding health care at the local level. Our office in Lynnfield is very satisfied with the treatment and care that our veterans receive at the Bedford health facility. They receive excellent care and the cases are handled in a professional manner.

Also, the veterans walk-in clinic at Lynn also provides our veterans with much needed assistance. Just last week at our American Legion meeting, one of our members was very grateful to the treat-

ment that he receives from the Jamaica Plain facility regarding his prostate condition.

I have one concern. My office has this concern. I do receive many referrals from veterans who are not eligible for many services only because they do not qualify. They do not receive any disability. These are veterans of World War II and Korea and they are getting up there in years and now they feel that they would like some kind of assistance, but they are not qualified. I wonder if that matter could be looked into. Thank you.

[The prepared statement of Mr. Restani follows:]



Town of Lynnfield, Massachusetts

#22)



VETERANS' SERVICES
NEIL F. RESTANI, *Director*

55 Summer Street
Lynnfield, Massachusetts 01940

781-334-3128

30 MARCH 2000

RE: VA HEALTH CARE AT THE LOCAL LEVEL

OUR OFFICE IN LYNNFIELD, MA. IS VERY SATISFIED
WITH THE TREATMENT AND CARE OUR VETERANS RECIEVE
AT THE BEDFORD, MA. HEALTH FACILITY.

THEY RECEIVE EXCELLENT CARE AND THE CASES ARE HANDLED
IN A PROFESSIONAL MANNER.

THE VETERANS WALK-IN CLINIC IN LYNN, MA. ALSO PROVIDES
OUR VETERANS WITH MUCH NEEDED ASSISTANCE.

MOST SINCERELY,

Neil F. Restani

NEIL F. RESTANI
VETERANS' AGENT

Mr. SHAYS. Thank you very much. I am going to try to get an assessment of how many more speakers we have, if you would raise your hand. Those are the eight speakers, so we are going to have to move along. If you can be closer to 2 minutes, it would be great, but we will live with 3.

Yes sir.

Mr. OUELLETTE. Mr. Chairman and panel, my name is Joseph Ouellette. I am a disabled combat veteran having served with the U.S. Army in Vietnam with 173rd Airborne Brigade.

I am here to represent the Essex County Correctional Facility. I am the veterans outreach coordinator and I also do the HIV coordination with the hepatitis C virus. So there is a link between veterans and the hepatitis C/HIV and there is also a tremendous link because 90 percent of the incarcerated people are in there because of substance abuse.

So what I have found for 10 percent being the veterans' population, I have approximately 120, 130 veterans. Most of them do not know that they have any veterans' benefits at all and the crimes committed are because they have a substance abuse issue. Most of my connections have been with the Bedford VA, the homeless shelter in Boston, and the veterans mansion in Haverhill which has been a tremendous asset to help out.

My question or my concern is in the future let us not forget about the incarcerated veteran. OK? Thank you.

Mr. SHAYS. Thank you, sir. I am struck, sir, by the fact that your comments are very well taken, I mean as are all the others, but sometimes that group does get overlooked.

Mr. SMITH. Good afternoon, Mr. Chairman.

My name is Arthur Smith. I am the past department commander for the State of Massachusetts, the American Legion and I would ask your indulgence because I have a statement here projecting what the American Legion feels about this—

Mr. SHAYS. Let me just say though if it is longer than 3 minutes, it needs to be submitted and you need to summarize.

Mr. SMITH. This is from past national commander, John P.J. Komer and past national commander, Anthony T. Jordan. Mr. Chairman and members of the subcommittee, the American Legion continues to follow the changes in health care delivery in New England with great interest.

The American Legion appreciates the opportunity to submit its observations and concerns regarding the impact and restructuring and the resource allocation of delivery of quality VA health services on the national, regional and local level. The American Legion will address the specific issues identified in the invitation to submit testimony, the VA budget for fiscal year 2001 and the VISN 1 budget for fiscal year 2001 and access care for the veterans infected with hepatitis C.

The American Legion has previously acknowledged the administration's request of \$20.3 billion to veterans' health care as reasonable, although the American Legion believes that the President's budget requests falls short of the required spending level for several reasons. The American Legion recommends that the VA health care receive \$20.5 billion appropriation for fiscal year 2001. First,

the American Legion questions the VA projections of medical care collection fund, called MCCF and sharing other collections.

The President's fiscal year 2001 budget request is based, in part, on the availability of a cost of \$600 million from MCCF and another \$115 billion from sharing in other collections. The revenue sources that compromise these funds include veterans co-pays, third party insurance and contracts with the Department of Defense and Tricare.

Since the enactment of legislation allowing VHA to transfer revenues from MCCF fund, the administration projections have been off in each of the past 2 years. National projection fell nearly \$100 billion short of projections to the fiscal year 1999.

In VISN 1 alone, the overestimate was \$14 million, just under 2 percent of its total VERA budget. VHA has made adjustments to its formula in projecting collections. Despite these adjustments however, the American Legion is not fully convinced that the projected collections for fiscal years 2000 and 2001 by VHA are accurate. This lack of confidence is not due to the lack of consideration of VHA's effort, rather it is attributed to the unknown ramifications for similar changes in policies and operations.

Mr. SHAYS. Can I ask you if you could summarize the conclusion and we will submit the whole thing?

Mr. SMITH. OK, sir.

Mr. SHAYS. Thank you sir, I appreciate your cooperation. We are just trying to make sure we get to votes this afternoon, there are votes on the floor of the House. That is our challenge.

Mr. SMITH. Finally, the American Legion is committed to the issues of the best care to veterans with hepatitis C virus, HCV. The American Legion has indicated strong support for VA programs geared toward increasing education among both veterans and providers that involve treatment of HCV, expanding VA treatment and research.

The national field services of the American Legion continues to monitor access to HCV treatment as well as other aspects of the HCV issue and a special focus within its oversight program.

Mr. Chairman, if I might be allowed to say on behalf of myself, when I entered the U.S. Air Force I raised my right hand. The government did not say if you were 10 percent, 20 percent or 30 percent service connected with a disability that we would take care of you.

The government said that if you needed health care, we will take of you and I know earlier this morning they were talking about lowering the requirements from 70 percent to 50 percent. I do not think that is fair enough to my fellow veterans that fought in World War II or my fellow veterans that fought in Korea. I think the limit should be down to 30 percent. Thank you, Mr. Chairman.

Mr. SHAYS. Thank you, sir. Yes sir.

[Applause.]

Mr. KOONTZ. Ron Koontz. I am the director of Veterans' Service for Amesbury. I am also a combat veteran from Vietnam, 1968, 25th Division and you can stop me after 1 minute.

What I would like to discuss is with the first panel was the disability claim process. I believe it was Dr. Murphy talked about the turnaround time for the initial claims. The 180 days does sound

good, but it is once that decision has been made, once it goes into the appeal process, there is definitely a long term wait on this, anywhere from 18 months to 3 years to 7 years and probably beyond.

The other issue would be I have gone through Boston JFK Building and I have seen stacks of claims on the floor at least 3 foot high and I hope this is not indicative of throughout the United States, but there does seem to be a backlog on the claims process. Thank you.

Mr. SHAYS. Thank you very much, appreciate it.

Ms. TROUBETARIS. My name is Maureen Troubetaris, I come here on behalf of my brother, John Day, served 1967 to 1971, United States Air Force Staff Sergeant, served in Vietnam, war veteran, served in Bangkok, Thailand as a crash fire fighter. My brother has been hospitalized for the past 14 months in the veterans hospital and cannot speak for himself. My family are his eyes and his ears and his mouthpiece. My greatest concern is the money available. You fund it for the veterans who have long term health care, health indeed necessities.

Two weeks ago today I got a call at work out of the clear blue sky from the veterans in Jamaica Plain and was told my brother ran out of benefits and where do I want him. It is 100 percent service connected, Vietnam War veteran and this was a shock to our family. Where would we place him?

Once they placed him in a nursing home and they almost killed him there. I guess my answer today is quality health care for all veterans, quality of where you place your veterans. There is no followup after you place your veterans in places that you contract out to. Some of these places that you have contracted to have great violations. You need to have a followup. There needs to be continuity in health care with the doctors. With long term health care, you do not have continuity in medical health care. Every month there is a new team of doctors. The only continuity is in the nursing staff. You need to have that for a family to understand.

I ask that the committee and I thank Congressman Tierney for all the help his office has given our family. It is a scary thing that my brother cannot speak for himself, but I do ask for help that you continue to finance all the veterans programs and look at the millennium bill as soon as possible. You cannot leave a generation of people, totally unprepared for long term health care at the mercy of this kind of treatment. Thank you.

Mr. SHAYS. Thank you for being a supportive sister on behalf of your brother, ma'am.

[Applause.]

Mr. TIERNEY. I want to note that Maureen is not only a good voice for her brother and family and veterans, but is a counselor in the city of Beverly.

Mr. PASSERI. Mr. Chairman, Representative Tierney, Angelo Passeri. I am a VA/VS deputy representative for the Vicotira Rocky Post and Beverly, a membership of 600 plus. I want to thank the panel. They covered every question that was presented to me by my membership. You did a fantastic job. You covered everything I wanted to cover.

I just want to augment one thing. When I heard one of the objectives that they had was to downsize the in-patient complement at

the Bedford Hospital. I got a little nervous because most of my recourse are to help gain access to that facility for our Alzheimer's and no doubt it is probably the best institution we have in the Nation.

I work very close with the first line staff and it is a showpiece and it hurts to see that we cannot gain admittance to that particular unit. And I just want to hope that you people will just keep in mind when we are talking about downsizing in-patient, that this facility and others like it are definitely needed. Please give this a lot of consideration. Thank you very much.

Mr. SHAYS. Thank you very much.

[Applause.]

Mr. SHAYS. Yes sir.

Mr. BOUCHER. Yes, my name is Gerard Boucher. I entered the Marine Corps December 15, 1966 when I was 19. Wounded October 11, 1967. I am an advocate for the blind and all disabled, veterans in quotation. First of all, I want to come up here and thank you all for a day like this. The Congressman, the Chairperson, all the dignitaries, everybody that had anything to do with this assembly. I am just sorry that there are not enough veterans here to stick up for themselves.

I came up here to mention two—one thing I got off my e-mail the Johnson amendment that just went through the Senate for the \$500 million, I heard the gentleman mention that earlier, I would like to see the House support that, if I could, and also this young lady that was up here earlier, just before me mentioned about her brother not knowing where to put him.

Now all this space after downsizing these medical facilities, Jamaica Plain, Brockton, Broadbury, what are they going to do with all that empty space? Are they going to utilize it or sell it or whatever? Would that not be a nice place for a nursing home for veterans? That is my suggestion.

There are a lot of things I would like to say, but I do not want the chairman to throw me out. This is what I really want to say, it is all in here, but I do not think you are going to give me the time.

Mr. SHAYS. Let me just say, sir, I would never throw you out and it is an honor to have you testify before this committee and it is an honor to know you have served so well for your country.

Mr. BOUCHER. And I want to thank you all again. Today like this here is what we need the most. You more you have of this, the better. And it is up to us to get the rest—

Mr. SHAYS. I have a feeling that when Mr. Tierney asked this committee to come up here he was thinking of you.

Mr. TIERNEY. This gentleman does a good job and he writes to my office at least once a month, always with pertinent information and insight and so we thank you very much for that.

Mr. BOUCHER. Thank you, sir. Thank you all.

Mr. SHAYS. Thank you. Sir.

Mr. LYONS. Thank you, Mr. Chairman. My name is Tom Lyons. I am the executive director of the New England Shelter for Homeless Veterans. I want to thank you for being here today and also thank my good friend, Congressman Tierney, for allowing me to be here today.

I am a former Marine. I served in 1967 to 1970 with a tour of duty in Vietnam in 1968.

Mr. Chairman, I run probably one of the largest homeless shelters in New England, 320-bed facility for men and women. We are unique, Mr. Chairman, because we are drug and alcohol free and our programs are based on structure and discipline, structure and discipline that these men and women had when they were in the military, we use it as a way of building them back to self-sufficiency.

We have emergency shelter, temporary housing and we also have permanent housing right inside our facility. We built a new medical clinic with the help of the VA. We are now not only providing basic medical care, but we are providing complete eye exams as well as dental care.

We have a training program that over the last 3 years have put over 1,100 men and women back into the work force in Massachusetts at an average wage of \$12. So as you can see, Mr. Chairman, we are a program that works and I am proud to say that we have been a player within the veterans community over the last number of years.

But the concern I have today, Mr. Chairman, is that the VA is talking about doing away with detox programs and are leaning toward out-patient detox. As someone who sees 85 percent of our clients at our facility who are drug and alcohol dependent, to think of an outpatient kind of a detox program scares the hell out of me to be quite honest because we have men and women in our program 8 months to a year or to a year and a half who are drug and alcohol free.

They were able to do it because of the structure and the discipline and the counseling services that we have in our facility.

I ask you, Mr. Chairman, and I ask your committee to look at whatever the VA has in terms of surveys, whatever, to outpatient clinics and see if they actually work or is this just another way of creating another out source within the VA system. Thank you, Mr. Chairman.

Mr. SHAYS. Thank you very much. I would just like to note for the record, it is 1:18, so I think we are almost done with our speakers. We have one gentleman here. We have three speakers all on this side and I do need to limit it to that so we have three speakers left.

I am going to just before you speak, I just want to take note that Dr. Frances Murphy has been here the entire time. She could have left and she stayed and I appreciate that very much as well as Dr. Jeannette Post and I appreciate you staying here as a well, Doctor, as well as Mr. William Conte. It is important that you hear what the veterans say and I did not need to tell you that because you know that. You might be able to interact with one or two, but we need to make sure the record is straight, particularly on one issue dealing with counseling for women and also whether services are available throughout wherever you go.

We have three speakers left. I am also going to allow our gentlemen, the panel up here to just make a closing comment if they would like if they are short. I think maybe what we will do, Dr.

Murphy, I am going to have you respond to those two questions before we leave so that they are part of the record, afterwards.

Yes sir.

Mr. HINDS. Good afternoon, Mr. Chairman. My name is John Hinds and I would like to put a face behind some of what you have been talking about today. I am a disabled Vietnam veteran, a career employee in the Veterans Administration and a veteran who is suffering from hepatitis.

I would like to thank Dr. Murphy, Dr. Post, Mr. Conte, Mr. Martineau and Mr. Hogan this morning because they were kind enough to show me something that I have never seen as a VA employee. I am taking annual today from my job in order to come here and to thank personally Congressman Tierney for the work he does not only on behalf of disabled veterans, but also particularly my district. I live in Georgetown.

Since 1988 I have been an employee of the Veterans Administration and I have worked at the VA Regional Office and the Kennedy Building in Boston. I have worked at the VA Medical Center and Jamaica Plain and I have worked at the outpatient clinic in Boston and for the last 9 years I have worked on the staff at the Med Center in Boston.

I have never had anything lower than an outstanding performance appraisal on an annual basis and yet I have been frustrated in every attempt, despite my education which includes a Bachelor of Arts degree and several completions of several courses on a master's degree level. I have been frustrated because I see what is being given to the veterans on the front line basis.

Thank you, Mr. Martineau for your comments. They are very appropriate. I have been thwarted in my attempts to improve myself as a VA employee. I have gone from a grade 5 to a grade 6 in the 11 years that I have been with Veterans Administration and I have been labeled, despite being chosen as 1 of the 12 VA employees to give performance training and individual customer relations training to fellow employees as angry, troubled and frustrated in my attempts to improve myself and improve the care of service to veterans.

So I am the face behind which you have been talking about today. I just wanted to thank you for this hearing and I wanted to thank you for your help, but I would like to say if you do one thing today, please make an attempt to recognize the front line employees who are there for the veterans every day and yes, they are frustrated because of the inability to improve ourselves and to improve the system. Thank you.

Mr. SHAYS. Thank you very much, sir. Our second to last speaker.

Mr. THEMES. Good afternoon, gentlemen. I am Charles Themes, 22 years military service. I am retired military. Three major battle scars. I spent 26 months in Korea. There is 1,500 lost in Korea. We do not know where they are. We do not know if they are prisoners of war. I know Korea better than most of the students know this high school. I spent 26 months in Vietnam. I was in combat section in Vietnam. I jumped out of helicopters, 2nd, 3rd, 4th, 5th Corps, Laos and Cambodia borders.

And so I think a lot of my friends were lost over there. What I am saying is that military retirees and some of the veterans who were combat veterans have a lot of disabilities. I cannot get my teeth cleaned at the Veterans Administration with 22 years of military service, five honorable discharges and 6 years reserve. I cannot get my teeth cleaned. When I go to Veterans Administration to have my teeth cleaned they say head on down the road, that has been gone, Jack. I said that is there it was. That is where my helicopter is, taking me to Laos and Cambodia.

But I speak for a lot of men, not only retirees, but the veterans. But if they want to know about North Africa, I spent 3½ years in North Africa, if they want to know about Cuba, I spent 11 months in Cuba. I spent 11 months in the South Pole. I spent a lot of places in a lot of other areas. Islands in the Indian Ocean and when they look for a demo technician, we need you to do the work, you go out and do your job. We came back.

When I was relieved from the military service they said you are all set. I came to VA and they said there is a dental office down the street, get going. Thank you very much for your time and patience. Have a very nice day.

Mr. SHAYS. Thank you, you too, sir, and our final speaker from the floor. I am sorry, we have two speakers left.

Mr. CLARK. Good morning, Mr. Chairman, and Congressman Tierney. Thank you for giving me the opportunity to speak. My name is Larry Clark. I am a disabled Vietnam veteran. I was in the U.S. Air Force from 1965 to 1969. For the last 20 years I have worked with the veterans an employment specialist in the disabled veteran outreach program.

My statement to you is when we were talking about having enough drivers to bring the veterans to and from the hospitals it might be appropriate if possibly in the budget you could appropriate some funding for van drivers because we do have a good CBO program that is coming out of the shelter and that would be appropriate, if you could fund that in the budget.

Mr. SHAYS. Thank you, sir. Ma'am? You are our final speaker.

Ms. ZUBEREK. My name is Eleanor Zuberek. I am not a veteran. I am here speaking for my father who is not well enough to be here today. Congressman Tierney was kind enough to let me know about this in spite of the fact that I am frequently consorting with known Republicans.

I wanted to address the problem of transportation and waiting times at the VA hospitals too. I get my dad in and out of there myself. I have elected to work part-time so I can be there for him. I do not know how many veterans have somebody who is willing or able to do that or who is married to a saint who is willing to put up with that.

I want to tell you about 1 day last December, I just decided to summarize this into one experience we had. My dad called me in the morning and said he was not feeling well so I went flying over there and he is 82. He has service connected disabilities from World War II. He was having chest pains and his lips and his fingernails were turning blue.

I said let us go to Beverly Hospital. He said no because there had been an incident 2 years ago when we had called the VA in the

middle of the night and they said he is too sick, you cannot bring him here from Danvers, it is a 40-mile trip. Take him to Beverly, we give you permission. Well, the next day they did not know about that.

And my father got stuck with the bill, so he insisted this time that we call Roxbury and I take him down there. We got there probably 8:30 and 9 a.m. and we sat in the emergency room with a lot of people who were very, very sick until 6 p.m. when he could be seen. He had very bad pneumonia and he had been released from the hospital the previous week.

One of the men in the emergency room waiting with him had had bypass surgery 8 days before that. He waited longer than my father did, at least I think he did. They got there before we did. And I do not think this is unusual. We have been in there, I was waiting outside in the hall for my Dad to have chest x-rays and I met two men.

One came down from Togas to have some simple tests done and another one came down from White River Junction. This is to West Roxbury. With the distance reversed, my father would not have made it up there. He is too fragile to travel that far. Never mind, you are providing transportation. And I just want to say anything you can do for these guys, when you called them to serve their country they did not say let us study it for 60 days and we will see if it is affordable before we go.

Mr. SHAYS. Thank you very much for speaking for your Dad.

[Applause.]

Mr. SHAYS. In one way it is regretful to have our last speaker have such a negative message, but it is an important message to hear so I appreciate you sharing your remarks.

I would like to make sure I do not forget this, so I am going to do this now before I just ask for closing comments and thank David Rapallo who is the minority staff member who I appreciate his presence and always his participation as an equal in this committee, with Larry Halloran, the staff counsel and also Christine McElroy who I said I would identify as ultimately responding, Mr. Welsh, to your suggestion about a briefing on VA benefits by DOD before you are discharged.

She is going to give a card to you today and then we will give you the correspondence that we are going to have back and forth. It is something that we can easily deal with right away. And Gary Batt from Mr. Tierney's staff and Cara Siegel and Tony Cooper, as well as from my staff, Karen Shirest and from the subcommittee staff as well, Jason Chung and Suzanne French, Apex Reporting and also to Richard Carey who is in, fact, and Patrick O'Shay the student who has made our sound system work quite well.

Some of the problem was external and we appreciate how they have gotten the system to work so nicely. And it is a lot of hard work. We appreciate both of your participation. And also to Peabody Veteran Memorial High School. Mr. Tierney leaves nothing out. He saw the name veteran and he said this is the place it had to be.

I would just encourage, I realize, Dr. Murphy that the answer to the sexual trauma answer may be a little more complex, but if you

do not mind getting to the mike and just putting on the record, in general terms, to be followed by more extensive remark in writing.

Dr. MURPHY. Congress would pass legislation to make all veterans who sustained sexual trauma, whether men or women, eligible for counseling and treatment for that in the Department of Veterans' Affairs and we work closely with DOD and make sure we identify those individuals and get them into counseling.

The general eligibility rules after eligibility reform are that any veteran who served honorably and has an honorable discharge for 90 days or more can enroll for VA health care. They would undergo a means test, but all priority levels one through seven, are eligible to enroll in the VA at this time.

Mr. SHAYS. Any area of the country?

Dr. MURPHY. Any area of the country. This is nationwide.

Mr. SHAYS. So sometimes the policy may not be followed, but that is the rules, so one suggestion is to contact your local Congressman or woman to make sure that that service is provided and also as well, we are happy to assist, Mr. Tierney, as well in any of the work that he has done with his veterans.

Dr. MURPHY. And I am sure the network staff or headquarters staff would be happy to help us.

Mr. SHAYS. Right. To be aware of that problem and to be able to step in. Thank you very much. And gentlemen, I would just, very brief comments, I literally need to get a plane soon and Mr. Tierney, actually he needs to get on his way because you have a meeting on census before you get on the plane.

Mr. TIERNEY. And in fact, if you gentlemen might excuse me because we are good enough friends that we can talk to each other at any time. I am due over in Lynn where the issue of census is very important to us and we are taking some efforts today to make sure that we get a count so that all of the services to all of our citizens will, in fact, reflect our population.

So let me just thank all of our witnesses from the first panel very much for not only testifying but for staying and listening; to all of our members of the second panel, for all the good work that you do day in and day out as well as your testimony here today and to all of the veterans who both asked questions and made testimony and those that cared enough to show up or who were able to show up today and the representation that you made for all of those who were unable to attend. I look forward to working with all of you. I thank you, Mr. Chairman, and staff very much for having the meeting held here today.

Thank you.

[Applause.]

Mr. SHAYS. And I would be very remiss because everybody in this room knows one individual on my staff who does a tremendous amount of work with veterans, is himself a retired veteran and that is Harry Hoffmader and I want to thank him.

[Applause.]

Mr. SHAYS. We have not yet adjourned yet. If there is any comment that the four of you would like to make, if there is not, that is fine.

Mr. Welsh.

Mr. WELSH. Thank you, Mr. Chairman. I am from Connecticut, like you and if you ask me the question about party affiliation, you would like the answer, but I have and always will vote for Congressman Tierney.

Mr. SHAYS. You know what, in this committee we are Americans first and Republicans and Democrats second, just as you are when you risked your life for your country.

I thank all of you. This hearing is adjourned. I will be running out very quickly. I hope I do not appear to be rude, but I need to get to that plane. Thank you very much.

[Whereupon, the hearing was adjourned.]

[Additional information submitted for the hearing record follows:]



DEPARTMENT OF VETERANS AFFAIRS

VA New England Healthcare System
 Network Office, Building 61
 200 Springs Road
 Bedford, Massachusetts 01730

May 22, 2000

In Reply Refer To: 10N1

The Honorable Christopher Shays
 US House of Representatives
 Committee on Government Reform
 2157 Rayburn House Office Building
 Washington, DC 20515-6143

Dear Congressman Shays:

At the April 10, 2000, Congressional Hearing on "VA Healthcare in the New Millennium", several issues were raised that needed further clarification. We are providing the following information to clarify the issues raised:

- ◆ Gloucester, MA CBOC: The Bedford VA Medical Center received Congressional Approval for the Gloucester CBOC in April 2000. A community forum is scheduled for Friday, June 2, 2000 to discuss possible locations and solicit stakeholder support for this new outpatient clinic. The new CBOC is expected to be open for patient care in approximately six months.
- ◆ Eligibility for health care benefits related to sexual trauma - Title 38 USC 1720D and VHA Directive 10-95-030 provides that sexual trauma care and counseling services be provided to "overcome psychological trauma, which in the judgement of a mental health professional employed by the Department, resulted from a physical assault of a sexual nature, battery of a sexual nature or sexual harassment which occurred while the veteran was serving on active duty. Coordination of care is expanded to include treatment for physical conditions resulting from sexual trauma". Under the authority of Title 38 USC 1720D, there is no minimum length of service required to apply for sexual trauma care and counseling benefits.
- ◆ Patients receiving care in several Networks - Veterans only need to enroll once in VHA to receive health care services. When traveling to another Network or Medical Center, a computer inquiry can be made to the patient's "home" VA Medical Center to obtain enrollment information and clinical information (such as prescription profile and electronic medical record notes). During open testimony at the hearing, a veteran testified this process was not followed when he tried to register for care in Florida. We will work together with the Florida Network to ensure this situation does not reoccur.

Thank you for the opportunity to comment on the issues raised during the Congressional Hearing. If you have additional questions or need additional information, please contact me at 781-687-3412.

Sincerely,

Jeannette Chirico-Post
 Jeannette Chirico-Post, MD
 Network Director, VISN 1

Veterans Integrated Service Network (VISN 1)
 Massachusetts: VA Boston HCS, Bedford, Brockton, Northampton. **New Hampshire:** Manchester.
 Connecticut: VA Connecticut HCS. **Vermont:** White River Junction. **Rhode Island:** Providence. **Maine:** Togus



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April 10, 2000

Honorable Christopher Shays, Chairman
House Veterans' Affairs Subcommittee on Benefit
372-B Rayburn House Office Building
Washington, DC 20515

Dear Chairman Shays:

In lieu of personal testimony, The American Legion is submitting a written statement relative to VA Healthcare in the New Millennium. The American Legion requests that this statement be made part of the April 10, 2000 hearing record.

We appreciate your compliance with this request.

Sincerely,

John P. (Jake) Comer
Past National Commander
The American Legion

Anthony G. Jordan
Past National Commander
The American Legion



STATEMENT

OF

JOHN P. (JAKE) COMER, PAST NATIONAL COMMANDER
AND
ANTHONY G. JORDAN, PAST NATIONAL COMMANDER
THE AMERICAN LEGION

TO THE

SUBCOMMITTEE ON NATIONAL SECURITY,
VETERANS AFFAIRS, AND INTERNATIONAL RELATIONS
COMMITTEE ON GOVERNMENT REFORM
UNITED STATES HOUSE OF REPRESENTATIVES

ON

"VA HEALTHCARE IN THE NEW MILLENNIUM"

APRIL 10, 2000

STATEMENT OF
JOHN P. (JAKE) COMER, PAST NATIONAL COMMANDER
AND
ANTHONY G. JORDAN, PAST NATIONAL COMMANDER
THE AMERICAN LEGION
TO THE
SUBCOMMITTEE ON NATIONAL SECURITY,
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COMMITTEE ON GOVERNMENT REFORM
UNITED STATES HOUSE OF REPRESENTATIVES
ON
“VA HEALTHCARE IN THE NEW MILLENNIUM”

APRIL 10, 2000

Mr. Chairman and Members of the Subcommittee:

The American Legion continues to follow the changes in health care delivery in New England with great interest. The American Legion appreciates the opportunity to submit its observations and concerns regarding the “impact of restructuring and resource allocation on the delivery and quality of VA health services on the national, regional, and local level.”

The American Legion will address the specific issues identified in the invitation to submit testimony: the VA Budget for FY 2001, the VISN 1 budget for FY 2001, and access to care for veterans infected with the Hepatitis C virus.

VHA Budget

The American Legion has previously acknowledged the Administration’s request of \$20.3 billion for veterans’ healthcare as reasonable, although The American Legion believes the President’s budget request falls short of the required spending level for several reasons. The American Legion recommends that VA healthcare receive a \$20.5 billion appropriation for FY 2001.

First, The American Legion questions VHA’s projections for Medical Care Collections Fund (MCCF) and Sharing/Other Collections. The President’s FY 2001 budget request is based, in part, on the availability of approximately \$600 million from MCCF and another \$115 from Sharing/Other Collections. The revenue sources that comprise these funds include veteran co-pays, third party insurance, and contracts with Department of Defense and TriCare.

Since the enactment of legislation allowing VHA to transfer revenues from the MCCF fund, the Administration’s projections have been off in each of the past two years. Nationally, the projections fell nearly \$100 million short of the projection for FY 1999. In VISN 1 alone, the overestimate was \$14 million—just under two percent of its total VERA budget.

VHA has made adjustments to its formula for projecting collections. Despite these adjustments, however, The American Legion is not fully convinced that the projected collections for FYs 2000 and 2001 by VHA are accurate. This lack of confidence is not due to lack of consideration of VHA's effort; rather it is attributable to the unknown ramifications from several changes in policy and operations. The American Legion is concerned that these changes may act as intervening factors in the projected revenue formulas.

For instance, in just the current fiscal year, VHA is tasked with transitioning to Usual and Customary Charges, and implementing those provisions contained in the Millennium Bill that alter the amount of co-pay for veterans. In addition to the uncertainty posed by these changes, there is also growing concern within VHA with regard to receiving payment from TriCare contractors. The American Legion has received a preliminary report that indicates in one VISN alone, the regional TriCare is in arrears to the amount of nearly a half a million dollars.

VISN 1 VERA Allocation

With regard to the budget allocation for VISN 1, The American Legion reported in May 1999 that the "VA New England Health Care System had not positioned itself well as it turned the corner of the millennium." Therefore, The American Legion would like to take this opportunity to again express its appreciation for the special attention of the members of this subcommittee in voicing the budgetary concerns for this network. The American Legion believes that the concerns of its membership were well represented by all of the members of this subcommittee as evidenced by the \$1.7 billion increase to VHA's budget overall.

However, while the increased funding to VHA overall had a positive impact on VISN 1's budget authority for FY 2000, The American Legion remains concerned about the financial stability of the network despite the increase in the FY 2000 VERA allocation for VA New England. The revenue level for VISN 1 in FY 2000 is slated at \$828.7 million, or approximately a 5.5 percent increase over FY 1999. (VERA Handbook, 2000) To shine a different perspective on the resource situation within VISN 1 in FY 2000, though, one need look no further than Table 14 of the VERA Handbook. Even with the five and a half percent increase, VISN 1 has only realized a 1.21 percent net increase in revenues since FY 1996. (p. 43) More troubling though is the portion of this amount that is contingent upon first and third party reimbursements.

According to VISN 1's own Strategic Plan (dated January 14, 2000), \$33,345,000—over 4 percent—of the \$828 million is supposed to come from MCCF. Additionally, the discussion in their strategic plan continues by explaining that "The impact of reasonable charges is yet unknown, and along with the implementation on compliance, actual collections are projected to be lower and therefore increasing the financial pressure on this Network." (p. 38) Of the eight cost reduction actions identified in the Plan, only two involve restructuring patient care processes—increased contracting and expanded use of case management to facilitate more outpatient care. The remaining six actions are reductions in force, seeking buyout authority, reducing workman's compensation program expenditures, exploring additional opportunities for commodity standardization, reducing utility costs, and reducing inpatient census levels. None of these improve quality of care, improve access to care, or improve timeliness to care.

The result seems to be a network mandated to absorb the cost of expanded access to emergency care, long term care, as well as the other provisions contained in the Millennium Act with substantially fewer employees and an uncertain ability to generate projected revenue. Moreover, this year's precarious budget situation follows on the heels of three years of budget reductions and increased concerns among all stakeholder groups in New England.

In May 1999, The American Legion discovered numerous complaints regarding access, not only in rural areas, but in the major tertiary referral facilities as well. One area of discord involved the VISN 1 transportation network. There were deficiencies found in the Togus to Boston route as well as within the Boston Beltway itself. The VISN was also in a position where it had become necessary to immediately transfer funds from MCCF to support operations, which given the difficulties collecting and the overestimation of revenues put the network in a tenuous financial position.

The American Legion is aware that interim management has made inroads towards correcting many of the previous administration's mistakes. The current version of the VA New England Health Care System Strategic Plan is up-front and comprehensive, and hopefully marks the beginning of a turn around in the relationship between the VHA and the veterans of the northeast. However, restoring stability to the organization will take more time and resources than a one-time budget increase—especially a budget increase that barely restores the resource level to that which it was in FY 1997.

Hepatitis C

Finally, The American Legion is committed to the issue of access to care for veterans with the Hepatitis C Virus (HCV). The American Legion has indicated its strong support for VA programs geared towards increasing education among both veterans and providers about treatment of HCV, expanding VHA treatment options, and VHA research. The National Field Service of The American Legion continues to monitor access to HCV treatment as well as the other aspects of the HCV issue as a special focus within its oversight program.

In closing, Mr. Chairman, The American Legion will monitor closely throughout the remainder of this fiscal year the progress of VISN 1 at improving the availability of healthcare services and the satisfaction of veterans. Another site visit will be coordinated through the new VISN Director's Office in the very near future. Based on the findings from this detailed examination of the operations within VA New England, The American Legion will continue to offer recommendations for FY 2001 budget spending as well as access to testing and treatment for veterans infected with the Hepatitis C Virus. Mr. Chairman this concludes our statement.

