VA HEALTH CARE: ACCESS DELAYED, ACCESS DENIED

HEARING

BEFORE THE

SUBCOMMITTEE ON NATIONAL SECURITY, VETERANS AFFAIRS AND INTERNATIONAL RELATIONS

OF THE

COMMITTEE ON GOVERNMENT REFORM

HOUSE OF REPRESENTATIVES

ONE HUNDRED SEVENTH CONGRESS

SECOND SESSION

OCTOBER 15, 2002

Serial No. 107–238

Printed for the use of the Committee on Government Reform

Available via the World Wide Web: http://www.gpo.gov/congress/house
http://www.house.gov/reform

U.S. GOVERNMENT PRINTING OFFICE

89–163 PDF WASHINGTON : 2003

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VA HEALTH CARE: ACCESS DELAYED, ACCESS DENIED

TUESDAY, OCTOBER 15, 2002

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

The subcommittee met, pursuant to notice, at 10 a.m., at VFW Post 63 Hall, 3008 Chinden Blvd, Boise, ID, Hon. Christopher Shays (chairman of the subcommittee) presiding.

Members present: Representatives Shays and Otter.

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

Mr. SHAYS. A quorum being present, the Subcommittee on National Security, Veterans' Affairs and International Relations' hearing entitled, VA Health Care: Access Delayed, Access Denied, is called to order.

The subcommittee convenes this hearing to continue our oversight of the Department of Veterans' Affairs, VA, health care system. We meet this morning in Boise, ID because Congressman Butch Otter asked us to focus on the unique challenges facing veterans and the VA in the Northwest service network. Congressman Otter is an active, extraordinarily active and very articulate participant in our efforts to make Federal programs more effective and efficient. It is a privilege and a pleasure to be here with him today. And I will say he didn't tell me I could wear jeans.

Regionalization of VA health care held the promise of delivery modes more directly tailored to local needs and funding levels more sensitive to area demographics. But rigid one-size-fits-all rules continue to produce systemic problems with access and waiting times in many regions. These chronic shortfalls are addressed only with an episodic infusion of supplementary resources. A more permanent approach is needed to match veterans' growing needs with VA health care capacity.

For a variety of reasons, including an attractive pharmaceutical benefit, many more veterans are seeking access to VA care. Medical centers and community-based outpatient clinics are hard-pressed to keep pace with demand relying on productivity increases alone. At some point, the quality of care will be affected if we continue to ask smaller medical staffs to serve more and more patients.

In this region, waiting lists have reduced slightly and patient satisfaction with the quality of care remains high, but as we will

hear in testimony, access to care for service-connected veterans can still be long delayed, in effect denied, amid the crush of enrollment applications by those in lower eligibility categories. So we ask our witnesses to describe how the VA health care system can be improved to become the agile, sophisticated, patient-centered provider envisioned by Congress. We welcome them, and we look forward to their testimony.

And I would just like to say I have been in Boise before, I love being here. It is a great community, a wonderful State, and I was happy that Butch asked more than once that we come and to say that this subcommittee is delighted to be here. We look forward to the testimony from our witnesses, and we will invite any—at the end, we will invite of those who are in attendance today to address the committee. We won't swear you in like we will our panel one and two, but we will invite you to make testimony to this committee if you would like to.

At this time, the Chair would like to recognize Mr. Otter.

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

SUBCOMMITTEE ON NATIONAL SECURITY, VETERANS AFFAIRS,
AND INTERNATIONAL RELATIONS
Christopher Shays, Connecticut
Chairman
Room B-372 Rayburn Building
Washington, D.C. 20515
Tel: 202 225-2548
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Statement of Rep. Christopher Shays
October 15, 2002

The Subcommittee convenes this hearing to continue our oversight of the Department of Veterans' Affairs (VA) health care system. We meet this morning in Boise, Idaho because Congressman Butch Otter asked us to focus on the unique challenges facing veterans and the VA in the Northwest service network. Congressman Otter is an active and articulate participant in our efforts to make federal programs more effective and efficient. It is a privilege and a pleasure to be here with him today.

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For a variety of reasons, including an attractive pharmaceutical benefit, many more veterans are seeking access to VA care. Medical centers and community based outpatient clinics are hard pressed to keep pace with demand relying on productivity increases alone. At some point, the quality of care will be affected if we continue to ask smaller medical staffs to serve more and more patients.

In this region, waiting lists have reduced slightly and patient satisfaction with the quality of care remains high. But as we will hear in testimony, access to care for service-connected veterans can still be long delayed, in effect denied, amid the crush of enrollment applications by those in lower eligibility categories.

So we asked our witnesses to describe how the VA health care system can be improved to become the agile, sophisticated, patient-centered provider envisioned by Congress.

We welcome them, and look forward to their testimony.

Mr. OTTER. Well, thank you, Chairman Shays, and I appreciate you accommodating us and holding this meeting in Boise. I also appreciate all of your efforts and your accommodation on all our logistical changes, because I think as the entire audience knows, we had to constantly change time and place as a result of most of our activities, or in some cases inactivity, in Washington, DC. And so I also want to say that I appreciate all the witnesses and them making the accommodations that they had to make in order to be here today.

Ensuring veterans have adequate access to care at the Veterans' Administration is an important issue. In the last 7 years, the number of veterans using the VA health system has doubled. The VA anticipates an increase of another 600,000 next year. Changes to the VA eligibility standards, the high quality of care delivered by the VA and the existence of the VA drug benefit have all added to the increased demand of the VA services.

Given this increase in enrollment it is easy to see why veterans in Idaho sometimes wait about a year, in some cases longer, just to get into see a VA doctor. In fact, there are approximately 3,000 veterans today waiting in Idaho, and about two-thirds of those veterans are priority 7 veterans. However, once in the system Idaho veterans seem to be very pleased with the delivery of the care service that they receive.

Some have predicted that the creation of a Medicare prescription drug benefit would help to relieve some of the backing of the VA, one which both you and I voted for. Unfortunately, the Senate has not followed likewise. Although the House passed the legislation in creating a Medicare drug benefit in June, the Senate, as I said earlier, did not follow suit. That left the Veterans' Administration again to deal with the high number of veterans waiting to receive care.

In May, this subcommittee held a hearing examining the structured problems that are causing the backlog of VA hospitals all over the country. During that hearing, I expressed my deep concern that a system of prioritizing veterans on the waiting list was not in place. I am pleased to report that on September 26 of this year the Veterans' Health Administration issued a directive entitled, "Priority of Outpatient Medical Services and In-Patient Hospital Care." Under this directive, the Veterans' Administration will now give preference to priority 1 veterans who have a service-connected disability and a rating of 50 percent or higher and will make every effort to see that those veterans within the next 30-day period receive such admission.

I believe this directive is a step in the right direction in providing veterans with more timely access to the care that they need. However, the Veterans' Administration estimates that there are over 280,000 veterans nationwide who will wait 6 months or longer for an appointment with a Veterans' Administration doctor. This directive will certainly help reduce that number, but the logistical and financial burdens of complying with this directive will be a challenging one for the Veterans' Administration.

I look forward to hearing from those representing the VA on how they are proceeding in that process. So as we explore ways to improve the Veterans' Administration's ability to address the health

care needs of veterans, I think that it is important to factor into the equation a way to provide the VA with the necessary resources, regulatory or financial, to address those increasing administrative workloads.

These hearings are an important chance for us and for your representatives in Congress to listen, to find out your thoughts on how we can best change the structure of the VA medical system to better accommodate the needs of Idaho's veterans. Mr. Chairman, I appreciate your leadership and your interest. I appreciate all of the hearings that you have had on this and the deep and sensitive concern that you have shown to every panel member that has come before us, not only today but also in Washington, DC. Thank you very much.

[The prepared statement of Hon. C.L. "Butch" Otter follows:]

MEMO

To: Congressman Otter
From: Brandon Heiner
RE: Hearing: "VA Health Care: Access Delayed, Access Denied?"
Date: October 11, 2002

Opening Statement

- I would like to thank Chairman Shays for holding this hearing and appreciate your accommodation of all the logistical changes. I also appreciate the witnesses and everyone else in attendance and their patience with the alterations in the schedule.

- Ensuring Veterans have adequate access to care at the VA is an important issue. In the last seven years, the number of veterans using the VA health system has doubled. The VA anticipates an increase of another 600,000 vets next year.

- Changes to the VA eligibility standards, the high quality of care delivered by the VA, and the existence

of the VA drug benefit have all added to the increased demand for services.

- Given this increase in enrollment, it is easy to see why veterans in Idaho sometimes wait about a year, and in some cases longer, just to get into see a VA doctor.

- In fact, there are approximately 3 thousand veterans waiting for care in Idaho and about two-thirds of those veterans are priority 7 veterans. However, once in the system, Idaho veterans seem to be very pleased with the delivery of care and quality of service they receive.

- Some have predicted that the creation of a Medicare Prescription Drug benefit would help to relieve some of the backlog at the VA. Although the House passed legislation creating a Medicare drug benefit in June, the Senate did not follow suit. That left the VA to again deal with the high number of veterans waiting to

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- Under this directive, the VA will now give preference to Priority 1 veterans who have a service-connected disability rating of 50 percent or higher, and will make every effort to see those veterans within 30 days.

- I believe this new directive is a step in the right direction in providing veterans with more timely access to care. However, the VA estimates that there are over 280,000 veterans nationwide who will wait six months or longer for an appointment with a VA doctor.

- This directive will certainly help to reduce that number, but the logistical and financial burdens of complying with this directive will be a challenge for the VA. I look forward to hearing from those representing VA on how they are proceeding in that process.

- So as we explore ways to improve the VA's ability to address the healthcare needs of veterans, I think it is important to factor into the equation a way to provide the VA with the necessary resources, regulatory or financial, to address these increasing administrative workloads.

- These hearings are a chance for us, your representatives in Congress, to listen. To find out your thoughts on how we can best change the structure of the VA medical system to better accommodate the needs of Idaho's veterans.

- Mr. Chairman, I appreciate your leadership and interest in this issue and I look forward to the testimony of the witnesses.

Mr. SHAYS. Thank you. I thank the gentleman. First, before calling our—recognizing our panel and swearing them in, I would like to get some housekeeping out of the way and ask unanimous consent that all members of the subcommittee be permitted to place an opening statement in the record and the record remain open for 3 days for that purpose. Without objection, so ordered. I ask further unanimous consent that all witnesses be permitted to include their written statement in the record. Without objection, so ordered.

I would also like to note the presence of Major Ed Freeman, a Congressional Medal of Honor recipient. This committee is honored that he would be here. Thank you so much for being here.

And to say that he earned this recognition in his service in 1965 and 1966 and recently received this long overdue recognition, and to say that it takes my breath away to think of the number of flights that he made, I think nearly 30, into an area that was totally and completely surrounded by the enemy and over 300 men were saved, in large measure, because of what he did. I would also point out that many of the enemy—we lost over 300 men that day or during that battle, and I think that the North Vietnamese lost nearly 2,000. So it is an honor to have you here.

But it is also an honor to have everyone who has served our country. This committee is profoundly grateful, and I can tell you without hesitation when a Congressman looks at our flag we try to see this flag through your eyes and recognize that when you look at this flag you think of the men who never came home, and you think of the conversations you had with family members about their lost loved one.

I would also like to recognize any family members who are here and just say thank you for supporting your family member in their service to our country. I think sometimes it takes more out of the family member than it does out of the soldiers who are actually serving in the battle.

At this time, the committee will recognize our first panel. Colonel Mitchell Jaurena is a veteran—did I say your name correctly?

Mr. JAURENA. Close enough.

Mr. SHAYS. I want it accurate.

Mr. JAURENA. Jaurena.

Mr. SHAYS. Jaurena. Thank you. That is the way it was——

Mr. OTTER. Is that Irish?

Mr. JAURENA. Basque Irish. [Laughter.]

Mr. SHAYS. Colonel, great to have you here.

Mr. JAURENA. Thank you.

Mr. SHAYS. We have as well—so the Colonel is a veteran. We have Mr. Lee Bean, a veteran; Mr. William T. Smith, a veteran; Mr. Richard W. Jones, administrator, the Idaho Division of Veterans' Services, which is the State provision for veterans. At this time, as you may know, we swear in all our witnesses. I have been chairing the committee now for 8 years, and I will tell you the only witness I have not sworn in was Senator Byrd, I chickened out and regret it to this day. [Laughter.]

Would you please stand.

[Witnesses sworn.]

Mr. SHAYS. We will note for the record all our witnesses have responded in the affirmative, and Colonel Jaurena, we will invite you

to address us first. And we have a 5-minute rule, but what we do is we allow you to go into the next 5 minutes and ask that you stop before 10.

Mr. JAURENA. Yes, sir.

Mr. SHAYS. But as close to 5 as you can be is appreciated.

STATEMENTS OF MITCHELL A. JAURENA, USMC RETIRED, VETERAN; E. LEE BEAN, VETERAN; WILLIAM T. SMITH, VETERAN; AND RICHARD W. JONES, ADMINISTRATOR, IDAHO DIVISION OF VETERANS' SERVICES

Mr. JAURENA. Good morning, Mr. Chairman and Representative Otter. I am Lieutenant Colonel Mitchell Jaurena, U.S. Marine Corps, retired. I was transferred to the Permanent Disability Retirement List on July 1, 2001 after 21 years of honorable service because of the degenerative nature of injuries I received during Operation Desert Storm while in the Persian Gulf. Upon my retirement, I moved back to Idaho and settled in Nampa. At that time, I attempted to enroll in TriCare Prime, the military system of health care, but was unable to find a local provider, as no physician or medical provider in the Treasure Valley region was accepting, or is accepting, TriCare Prime patients. Subsequently, however, on November 6, 2001, the Department of Veterans' Affairs rated me as a 50 percent service-connected disabled veteran. Now, as a priority 1 category disable veteran, I was automatically enrolled in the Veterans Health Care system and during December 2001, the Boise VA hospital issued me my veterans universal access identification card and assigned me to a health care team in Boise, ID.

Unfortunately, I was also told at that time that I would be unable to utilize the Boise VA hospital for any care other than emergency care, as there was a 2 to 2½ year-long waiting list at the hospital for assignment to a doctor. I was also told that I would be unable to utilize the pharmacy, even if I had a script provided by a non-VA doctor, as the pharmacy was only available to those with assigned VA doctor at the Boise hospital. I was also told that there was a 2 to 3-year wait to receive optical care but hat I would be able to obtain those glasses if I could provide them with the prescription from an outside pharmacist.

Mr. Chairman, I find it absurd that a combat-related 50 percent disabled veteran with service connection should be required to wait for medical care at a VA hospital while those without service connection are receiving care. I find it even more patently absurd that a priority 1 service-connect disable veteran should have to wait up to 2½ years for the assignment of a VA doctor just to be able to fill a prescription at the VA hospital while they are under the care of a private physician.

But I do need to point out, as Representative Otter did, that the landscape has recently changed. The Secretary Principi has directed that these 50 percent disabled veterans, priority 1 veterans, receive care. And as of this time, I have an appointment on October 24, so I will have waited 11 months to receive care at this hospital.

Now, it is really hard to overcome 21 years of training provided by the Marine Corps. No Marine complains without providing an alternative solution, but I do realize that Federal funding is not a bottomless well, and there simply isn't enough money to go around.

I also realize that some veterans will eventually go without. There have been various plans proposed also by various service organizations, some of them to include a financial means test for veterans seeking care, in essence, turning the VA health care system into a welfare health care system. I am against any financial means test as an eligibility requirement for health care. The only eligibility requirement for health care I would support is already in place and that is honorable service in the armed forces of the United States of America in service of our country.

I do believe that those with the highest need based upon service connection disability ratings should be seen first. The VA already has a priority health care system for enrollment in place. This prioritization starts with priority 1 for 50 percent or greater service-connected disability to priority 7 for non-service connected and non-compensable disabled veterans. I believe that this already-established system should also be used for providing health care and scheduling appointments so that those who have honorably served and have suffered the most will receive the first use of the limited assets available.

Now, if we use the health care system, will veterans fall out if we use that prioritization? Absolutely. Will they be deserving of care? Certainly. However, this method of prioritization will allow for the most disabled to receive care and give Congress and the VA a clear picture of those veterans left without VA-provided health care. It would allow Congress to decide on the level of funding that it is willing to allocate based upon veterans' needs. It would also be up to our elected officials to reflect the will of the American people to fund or not fund for the care of its veterans. Thank you for the opportunity to testify.

[The prepared statement Mr. Jaurena follows:]

LtCol Mitchell A. Jaurena, USMC (ret)
5101 Blue Jay Loop
Nampa, ID 83687

Good morning, Mr. Chairman and subcommittee members. I am LtCol Mitchell A. Jaurena, United States Marine Corps, retired. I was transferred to the Permanent Disability Retirement List on 1 July 2001 after 21 years of honorable service because of the degenerative nature of injuries I received during Operation Desert Storm while in the Persian Gulf. Upon my retirement, I moved back home to Idaho and settled in Nampa. At that time I attempted to enroll in TriCare Prime, but was unable to find a local provider as no physician or medical provider in the Treasure Valley region is accepting TriCare Prime patients. Subsequently, on 6 November 2001, the Department of Veterans Affairs rated me as 50% service connected disabled. As a Priority One category disabled veteran, I was automatically enrolled in the Veterans Health Care system and during December of 2001 the Boise VA hospital issued my Veterans Universal Access Identification card and assigned me to a health care team at the Boise VA hospital.

Unfortunately, I was also told at that time that I would be unable to utilize the Boise VA hospital for any care, other than emergency care, as there was a 2 to 2.5 yearlong waiting list at the hospital. I was told that I would be unable to utilize the pharmacy even if I had a script provided by a non-VA doctor as the pharmacy was only available to those with an assigned VA doctor at the hospital. I was also told that there was a 2 to 3 year wait to receive optical care, but that I would be able to obtain glasses if I could provide them a prescription from an outside optometrist.

Mr. Chairman, it is absurd that a combat related 50% disabled veteran with service connection should be required to wait for medical care at a VA hospital while those without service connection are receiving care. I find it even more patently absurd that a Priority One service connected disabled veteran should have to wait up to 2.5 years for the assignment of a VA doctor just to be able to fill a prescription at the VA hospital while they are under the care of a private physician.

I do need to point out that recently the landscaped has changed regarding the prioritization of 50% disabled service connected veterans. Secretary Principi has directed that 50% disabled service connected veterans would be given priority appointments at VA Hospitals and that those on the waiting list would be contacted and given initial appointments within 30 days of 1 Oct 2002.

Now it is hard to overcome 21 years of training provided by the Marine Corps. No good Marine complains without providing an alternative solution. I do realize that Federal funding is not a bottomless well and that there simply isn't enough money to go around. I also realize that some veterans will go without. There have been various plans proposed to include a financial means test for all veterans seeking care, in essence, turning the VA healthcare system into a welfare health care system. I am against any financial means testing as an eligibility requirement for healthcare. Mr. Chairman, the only eligibility requirement I would support is already in place and that is honorable

service in the armed forces in the service of our country. I believe that those with the highest need based upon service connected disability ratings should be seen first. The VA already has a priority system in place for health care enrollment. This prioritization starts with priority one for 50% or greater service connected disability to priority seven for non-service connected and non-compensable disability veterans. I believe that this already established system should also be used for providing health care and scheduling appointments so that those who have honorably served and have suffered the most receive first use of the limited assets available.

If we use that system will veterans fall out the bottom? Absolutely. Will they be deserving of care? Certainly. However, this method of prioritization will allow care for the most disabled and give Congress and the VA a clear picture of those veterans left without VA provided health care. It will also allow Congress to decide on the level of funding that it is willing to allocate based upon veterans' needs. It would then be up to our elected officials to reflect the will of the American people to fund or not to fund for the care of its Veterans.

Thank you for the opportunity to testify.

Mr. SHAYS. Thank you very much, Colonel. Would you move that pitcher so that you could see the light too?

Mr. JAURENA. Yes. I beat it by 12 seconds, Congressman.

Mr. SHAYS. Thank you. It was an excellent statement. Excellent statement.

Mr. BEAN. OK. Are you ready for me?

Mr. SHAYS. We are, Mr. Bean. Thank you so much.

Mr. BEAN. OK. I am not disabled or anything, I am in pretty darn good shape, except what I have to say here. I served in the Navy during World War II aboard ship, and after hearing that several veterans my age, World War II, getting more income than I do are receiving prescriptions drugs from the VA——

Mr. SHAYS. I am going to ask a question. Can people in the back hear what is being said right now? Let me just say I apologize for not being able to pick you up. I am going to ask you—and I am sorry about that, but I am going to ask you to hold it up, because I think it is important that everybody hear your statement.

Mr. BEAN. My voice is not that good either.

Mr. SHAYS. Yes. Colonel, I apologize for that.

Mr. BEAN. OK. I can certainly start over then.

Mr. SHAYS. I apologize, yes.

Mr. BEAN. U.S. Navy during World War II, and I heard of veterans receiving prescription drugs from the VA that are in a similar conditions I am, with more income than me, actually, a lot of them, and so I decided on December 21, 2000 I went to the VA Center and enrolled for benefits, gave them my financial so on and so on. Then in May 2001, after coming home, I found out that friends of mine had been receiving prescription drugs without even filling out a financial statement in other VA hospitals. So then I went to the—called the VA Center and the nurse told me to come down in an emergency condition. So I went down and was right in and saw a PA, a nurse's physician's assistant, and she examined me, questioned me and using my doctor's prescription enrolled me to start receiving drugs, which I did for about 1 year. In February 2000, I updated my income status. In March of this year, I was informed by the VA that I would no longer receive drugs because I had not been able to see a doctor. I then contacted Mr. Otter and other Congressmen, representatives about this.

It is my belief that if prescription drugs are going to be available for some veterans, they should be available to all veterans, especially after age 65 whenever you have now become on Social Security and limited income, also a lot of us being in those notch years where we don't receive as much Social Security as other people. I think that the VA should be able to use my doctor. I belong to an HMO, I have a doctor who writes my prescriptions. Why can't I take them to the VA? Why can't they trust my doctor? They're both being paid by government funds. That's all I am asking.

Now, if it is not available for me, let us not make available for other people in my situation. I don't have a Purple Heart, I have a lot of close calls in Australia while I was in the Navy, I know that. But I know my wife is 73, I am 77, and we both work part-time to supplement our income. So I am not afraid of that, I am able to do it. That is about all I have to say. Thank you.

[The prepared statement of Mr. Bean follows:]

TO: THE SUBCOMMITTEE ON NATIONAL SECURITY, VETERANS AFFAIRS AND INTERNATIONAL RELATIONS

FROM: E. LEE BEAN, WWII VETERAN SERVING ABOARD U.S.S GANYMEDE, SOUTH PACIFIC THEATRE

After hearing from other veteran friends that they receive prescription drugs from the Veterans Administration Hospital I contacted the Boise Center, received information and forms to complete, and on:

December 21, 2000 went to Boise VA Center and enrolled for benefits. Received card and was informed that I would be put on list and would be called in about six months. Veteran friends from other areas told me they were seen by a VA doctor and started receiving drugs without delay.

May 1, 2001 Called nurse at Boise Center to find out about my status. The nurse told me to come in on an emergency basis to the outpatient office. I was examined and questioned by a PA and using my regular doctor's prescriptions she ordered compatible drugs to be mailed to me.

February 2002 I updated my income status by phone.

March 11, 2002 Informed that I would not receive additional drugs because I had not seen a VA doctor. All calls to the VA Center resulted in a common answer "You're on the list".

I am not affiliated with any private or government organization and have acted alone in my pursuit to receive prescription drugs. I have contacted Idaho Congressmen and Senators to inform them of my dilemma.

It is my belief that all veterans at age 65, below a designated income level, should receive drugs using his or her doctor's prescriptions. This would enable VA doctors more time for veterans who are under 65 and do not have any health insurance. Being on a list does nothing to pay for necessary life saving drugs. My wife (age 73) and I (age 77) still work part time to supplement our social security income.

Thank you,

E. Lee Bean
544 Weaver Avenue
Boise, ID 83704
(208) 376-9278
October 1, 2002

Mr. SHAYS. Thank you very much, Mr. Bean. That is very helpful testimony as well. Mr. Smith. Evidently, these are mics you have to have pretty close up to you.

Mr. SMITH. Can you hear me?

Mr. SHAYS. We hear you great.

Mr. SMITH. Honorable Congressmen, ladies and gentlemen, my name is William T., Tom, Smith, and I am here to speak—my reasons for speaking are the very deplorable treatment to myself and other veterans who are being subject to what I feel is a completely overloaded and broken down VA system. They are trying to do their best, but they can only do so much. They are drastically understaffed and underfunded.

First, they have no cardiac care unit at Boise VA. For heart treatment, they send you to Seattle VA. When I had my heart attack in 1996, I spent 5 days at the Boise VA waiting for space to be transferred to Seattle VA. It took more than 5 days to be evaluated by a cardiac specialist after a heart attack. This is very hard on patient and family after going to Seattle twice for heart treatment in a very crowded system, the stress of traveling and being separated from family at such critical times. The next time I had a heart problem I requested to be transferred to St. Luke's for quicker evaluation, and it was a good thing I did. I was near another heart attack, and I had immediate bypass surgery, it was a six-way bypass. The VA denied co-payment on this surgery, and I was left with all the bills my private insurance did not cover.

Mr. SHAYS. Mr. Smith, could you just turn the mic the other way a little bit? Yes.

Mr. SMITH. I am rated 100 percent service connected. My first trip to Seattle they did an angiogram, the second they did an angioplasty scan implant. The VA always bills my private insurance for all the treatments and surgery and prescriptions. The real funny thing about all of this is it would be cheaper for the VA to pay the co-payment than fly me to Seattle, and yet they denied the co-payment. It does not make sense. I go to a cardiologist in private practice because there is not a cardiologist on staff at the Boise VA. They have one who comes in once a month for clinic, and you must meet certain criteria to be seen by him. This is almost a joke if it was not so serious.

Another problem is my hands. I had surgery on two fingers on my right hand for trigger finger. I have developed trigger fingers in my hand, two of them, and I have bone spurs on the right thumb. And this time it has taken me over a year to get an appointment for an evaluation. Surgery will be scheduled for a later date. In the meantime, my fingers are getting worse, and I can no longer open it fully. Gripping anything with my right hand is very difficult, and these conditions get worse daily and less correctable. When I asked my regular physician about a colonoscopy, I was discouraged about having one. It has taken over a year to get scheduled for a colonoscopy with the medical profession recommending you should have one after age 50. This just doesn't seem right.

The problems I have stated above plus some old back injuries have been shuffled off to a physician's assistant. I have not seen my regular physician for the last two scheduled appointments. In addition to the other problems, I have upper spinal injury which

causes tremors and excruciating pain in the arms and the shoulders. Plus I have had back surgery on the lower back and two hernia surgeries.

Parking is always horrendous at the VA. If you can find a place to park, it is generally three to four blocks away from the entrance, and some days it seems like you can't find any place to park there. They really need to do something about the parking there. The lab is another bottleneck when you go in and if you are going to have any blood work done or anything. It is not anything to see an hour's wait to have the lab work done. If you see your doctor and go to the lab and get a prescription filled, you can spend a day at the VA.

My suggestions would be to have the representative talk to the people at the VA, get their statements. If you catch them coming out of there real fresh, you can get some good input. I am sure they would tell you that they feel like cattle being herded through or just a number.

And the doctors are very reluctant about letting you see another doctor about your problem. One of the doctors at the specialty clinic will ask you how you are today. If you tell him you have some problems, he will tell you, "We are all getting older and expect the aches and pains to be worse." And then he will tell you to come back and see him in 3 months.

It is very reassuring to me to have you Congressmen investigating trying to assist us veterans with our health care problems. I truly hope my statements here will help others and assist you in your fact finding. With my sincerest thank you for working to make things better for the veterans. Please keep up the good work.

[The prepared statement of Mr. Smith follows:]

William T. Smith
1025 Lilac Lane
Emmett, Id 83617
October 11, 2002

Honorable Chairman Congressman Shays and
Honorable Congressman Butch Otter:

Honorable Congressmen:

My reasons for speaking are the very deplorable treatment that myself and other Veterans are being subjected to from what I feel is a completely overloaded and broken down V.A. system. They are trying to do the best they can but they are drastically understaffed and under funded.

First they have no CARDIAC CARE UNIT AT BOISE V.A. For heart treatment they send you to Seattle V.A. I had my heart attack in 1996, I spent five days at the Boise V.A. waiting for space to transfer to Seattle V.A. It took more than five days to be evaluated by a cardiac specialist after a heart attack! This is very hard on patient and family. After going to Seattle V.A. twice for heart treatment in a very crowded system the stress of traveling and being separated from family at such critical times. The next time I had a heart problem I requested to be transferred to St Lukes for quicker evaluation. It was a good thing I did I was very near another heart attack I had immediate by pass surgery it was a six way by pass. The V.A. denied co-payment on this surgery and I was left with all the bills my private insurance did not cover. I am rated 100% service connected. My first tri to Seattle V.A. they did an angio gram the second they did an angio plasy, stent implant. The V.A. always bills my private insurance for all of the treatments and surgery and prescriptions. The real funny thing about all of this is it would be cheaper for the V.A. to pay the co-payment than to fly me to Seattle for treatment. Yet they denied the co-payment it does not make sense. I go to a Cardiologist in private practice because there is not a Cardiologist on staff at the Boise V.A. They have one who comes in once a month for clinic and you must meet certain criteria to be seen by him. This is almost a joke if it was not so serious.

Another problem is my hands I have had surgery on two finger on my right hand for trigger finger. This is a condition where your finger will lock in the closed position and then it is very painful to straighten it out. I have since developed the condition in two fingers on the left hand and bone spurs in the right thumb. This time it has taken me over a year to get and appointment for evaluation. Surgery will be scheduled for a later date. In the meantime my finger is getting to where I can no longer open it fully. Gripping anything with my right hand is very difficult. These conditions get worse daily and less correctable.

When I asked my regular physician about having a colonoscopy I was discouraged about having one. It has taken over a year to get scheduled for a colonoscopy. With all the

medical profession recommending you should have one after age 50 this just does not seem right.

Problems I have stated above plus some old back injuries I am being shuffled off to a physician's assistant. I have not seen my regular physician for the last two scheduled appointments. In addition to the other problems I have upper spinal injury, which causes tremors and excruciating pain in the arms and shoulders. Plus I have had back surgery on the lower back and two hernia surgeries.

Parking is always horrendous most of the time you have to park at least three blocks away from the entrance. If you can even find a parking place. There really needs to be something done to alleviate the parking problem.

The lab is another bottleneck you have to wait some days as long as one and a half hours for lab. Then the pharmacy is really a bottleneck an hour to get a prescription filled is normal. A trip to see your doctor is a full day if you go to lab and get a prescription filled.

My suggestion would be send a representative to the V.A. and talk to the people about how they view their treatment at the V.A. Ask what they would like to see changed. I am sure they would tell you they feel just like cattle being herded through or just a number.

Doctors are very reluctant about letting you see another doctor about your problem. One of the doctors in the specialty clinic will ask how you are today if you tell him you have some problems. He will tell you we are all getting older and can expect the aches and pains to be worse. Then he will say well come back and see me in the three months.

It is very reassuring to find out you congressmen are investigating and trying to assist us Veterans with our health care problems. I truly hope my statements here will help others and assist you in your fact finding.

WITH MY SINCEREST THANK YOU FOR WORKING TO MAKE THINGS BETTER FOR THE VETERANS. PLEASE KEEP UP THE GOOD WORK.

Respectfully

William T. (Tom) Smith

Mr. SHAYS. Thank you, Mr. Smith, for your helpful statement. Mr. Jones. I am going to ask if anyone is in the back and can't hear, you just raise your hand and we will just make sure that I direct the witnesses to speak more into the mic.

Mr. JONES. Good morning, sir.

Mr. SHAYS. Good morning.

Mr. JONES. It is my pleasure to be here this morning and present the testimony on behalf of Patrick Teague who was not able to be here and was scheduled to actually provide testimony before you. I do have his written testimony before me. Patrick is our program supervisor of the Office of Veterans' Advocacy for the State of Idaho, so reading his testimony.

Committee members, veterans and guests, I wish to express my appreciation for being invited to speak on behalf of Idaho's veterans today. It is indeed an honor and a privilege to appear before you.

I would like to begin by saying the care at our VA medical centers serving Idaho's veterans is outstanding. Sure, you have the occasional horror story of a veteran who has been mistreated or neglected but these instances are few and even fewer once investigated. In my job as a veteran service officer, I speak to veterans and their dependents throughout the State, and almost to a person they all tell me that once they get through the door into the VA medical center, they receive excellent care. Which brings us to the reason we are here today: Access to our VA medical centers.

If you are a veteran who has been assigned a team, has a doctor or a physician's assistant, then you are indeed fortunate. If you are a veteran moving one State to another, you are facing a wait of up to a year or longer just to gain access to our VA medical centers. The exceptions to this are 50 percent service-connected veterans or those requiring emergency care. By far and away, however, the majority of new accounts are being told to get into an ever-increasing line and don't call us, we will you.

This is simply unacceptable and must be corrected. The real tragedy here is that as service officers we are told for years to go out and find those veterans who have never been enrolled in our VA medical centers and get them enrolled. When queried by the service officers if the medical center would be available to provide care for those veterans, the answer was a resounding yes, so we did. We went out and found those veterans who had never been in the system and had them submit their 10–10EZ forms. Some of those veterans are still waiting to be assigned a team. In the meantime, for every new account, or "uniques," as the VA calls them, the VA medical center gets approximately $1,5000 placed in their account. I have no problem with that, but I do not understand why the veteran is denied access if the VA medical center has received $1,500 for enrolling that veteran.

Another problem we have that I do not understand is when the Boise VA Medical Center cannot provide specialty care at the Boise VA Medical Center, they then schedule the veteran for care in Palo Alto or Seattle. If the veteran is sent to Seattle, the Boise VA Medical Center gives him $40 for a bus ticket to Seattle. The veteran then finds transportation from the bus depot to the Seattle VA Medical Center. When the veteran is finished with is stay in Se-

attle, he must get the Seattle VA Medical Center to give him $40 for his trip back to Boise. Once again, it is up to him to get from the VA Medical Center to the bus depot. Then he has the long bus ride back to Boise. In many cases, these veterans are convalescing and the bus ride takes its toll on them. Wouldn't it be better for the veteran and their families if the Boise VA Medical Center would refer them for specialty care at St. Luke's or St. Alphonsus? The Millennium Health Care Act states that if care in a VA medical center is not available, then the veteran should be referred to the community. They do not normally do it as it impacts the Boise budget more than they can afford. Clearly, something must be done for these veterans who fall through the cracks and are sent to other VA medical centers for their care.

We must also address the problem of proper funding for those who travel for a VA medical center appointment, as Idaho is one of the most rural States in the Union. Some of our veterans must travel over 500 miles roundtrip for a medical appointment. An example of this would be Salmon, ID in Lemhi County. Those veterans travel 252 miles one way to receive treatment at the Boise VA Medical Center. Veterans traveling to those appointments receive 11 cents per mile for that appointment, and some of them have $6 deducted from that travel allowance. Any appointment that is not for a compensation and pension examination will have the $6 deducted from the veteran's reimbursement, not to exceed $18 in 1 month. This is simply ludicrous because the VA medical centers are only reimbursing 11 cents per mile as it is. A raise is certainly in order to help alleviate the cost of traveling to and from an appointment.

In summation, I would like to reiterate that once in the door of the Boise VA Medical Center, the care is excellent. It is getting through that door that is the problem. We must secure more funding for our VA medical centers if we are to make a difference in the current situation. Our Nation's veterans deserve no less. Thank you for your attention.

[The prepared statement of Mr. Teague follows:]

Testimony by Patrick D. Teague
Subcommittee on National Security, Veterans Affairs, and International Relations
"VA Health Care Access Delayed, Access Denied/"
Monday, October 14, 2002
Veterans of Foreign Wars Post 63
3308 Chinden Blvd.
Garden City, ID 83714

Committee Members, Veterans, and Guests:

I wish to express my appreciation for being invited to speak on behalf of Idaho's veterans today. It is indeed an honor and a privilege to appear before you.

I would like to begin by saying the care at our VA Medical Centers serving Idaho's veterans is outstanding. Sure, you have the occasional horror story of a veteran who has been mistreated or neglected but this instances are few and even fewer once investigated. In my job as a veteran's service officer, I speak to veterans and their dependents throughout the state and almost to a person they all tell me that once they get through the door into the VA Medical Center, they receive excellent care. Which brings us to the reason we are here today - "Access to Our VA Medical Centers."

If you are a veteran who has been assigned a team, has a doctor or physician's assistant, then you are indeed fortunate. If you are a veteran moving from one state to another, you are facing a wait of up to a year or longer just to gain access to our VA medical Centers. The exceptions to this are 50% service connected veterans or those requiring emergency care. By far and away however, the majority of new accounts are being told to get into an ever increasing line and "Don't call us, we'll call you."

This is simply unacceptable and must be corrected. The real tragedy here is that, as service officers, we were told for years to go out and find those veterans who have never been enrolled in our VA Medical Centers and get them enrolled. When queried by the service officers if the Medical Center would be able to provide care for those veterans the answer was a resounding "Yes!" So we did. We went out and found those veterans who had never been the system and had them submit their 10-10EZ forms. Some of those veterans are still waiting to be assigned a team. In the meantime, for every new account or "uniques" as the VA calls them, the VA Medical Center gets approximately $1,500 placed in their account. I have no problem with that, but do not understand why the veteran is denied access if the VA Medical Center has received $1,500 for enrolling that veteran.

Another problem we have that I do not understand is, when the Boise VA Medical Center cannot provide specialty care at the Boise VA Medical Center, they then schedule the veteran for care in Palo Alto or Seattle. If the veteran is sent to Seattle, the Boise VA Medical Center gives him $40 for a bus ticket to Seattle. The veteran must then find transportation from the bus depot to the Seattle VA Medical Center. When the veteran is finished with his stay in Seattle, he must get the Seattle VA Medical Center to give him $40 for his trip back to Boise. Once again, it is up to him to get from the VA Medical Center to the bus depot. Then he has the long bus ride back to Boise. In many cases, these veterans are convalescing and the bus ride takes its toll on them. Wouldn't it be better for the veteran and their families if the Boise VA Medical Center would refer them for

specialty care at St. Luke's or St. Alphonsus? The Millennium Health Care Act states that if care at a VA Medical Center is not available, then the veteran should be referred to the community. They do not normally do is as it impacts the Boise budget more than they can afford. Clearly, something must be done for these veterans who "fall through the cracks and are sent to other VA Medical Centers for their care.

We must also address the problem of proper funding for those who travel for a VA Medical Center appointment as Idaho is one of the most rural states in the union. Some of our veterans must travel over 500 miles round trip for a medical appointment. An example of this would be Salmon, ID in Lemhi County. Those veterans travel 252 miles, one-way, to receive treatment at the Boise VA Medical Center. Veterans traveling to those appointments receive eleven cents per mile for that appointment and some of them have six dollars deducted from that travel allowance. Any appointment that is not for a compensation and pension examination, will have the six dollars deducted from the veteran's reimbursement, not to exceed eighteen dollars in one month. This is simply ludicrous because the VA Medical Centers are only reimbursing eleven cents per mile as it is. A raise is certainly in order to help alleviate the cost of traveling to and from an appointment.

In summation, I would like to reiterate that once in the door of the Boise VA Medical Center, the care is excellent. It is getting through that door that is a problem. We must secure more funding for our VA Medical Centers if we are to make a difference the current situation. Our Nation's veterans deserve no less.

Thank you for your attention.

Mr. SHAYS. Thank you very much, Mr. Jones; appreciate it. We are going to start off with Mr. Otter asking some questions, and I will have some questions as well. And if we ask one of you but another of you wants to answer the question as well, just jump in after that person is finished speaking.

Mr. OTTER. Well, thank you, Mr. Chairman, and I would direct this question to all of the panelists. During our hearings, several hearings, that we had earlier this year and one late last year, there were—obviously, we heard about an awful lot of horror stories, and I think that is what precipitated the priority 1 change that came about September 26. I can remember in the committee room me offering an example that I am prior service but I have no service disability, no service-connected disability. And yet if I showed up at the VA hospital with a rodeo accident, I would certainly be put ahead of, depending upon if I showed up on that priority list, I would be put ahead of anybody who may have gotten some disability as a result of any military action or any other military service. We thought that was patently unfair.

My question actually as a result of listening to several folks that testified and trying to come up with some sort of a recipe, if you will, that said that the level of service-connected disability coupled with age should bring us some sort of a ratio of setting priorities. Would you agree or disagree, and I am not prepared to say you have got to be a certain age with a certain disability, but would you agree or disagree with setting a priority, No. 1, based upon the disability and the level of disability and, No. 2, the age of that veteran that is disabled?

Mr. JAURENA. I will kick it off here, Representative Otter. I agree with you on the first part. Service connection and the type of disability, I would absolutely agree with that. However, it makes no difference whether you are 46 like I am or 76 is if you have a degenerative disease caused by a service injury that you are required to take medication for. As it stands now, I cannot get in to get my medication at the VA hospital simply because I have been bumped by priority 7 people. So I do not believe an age requirement is justifiable. You have a system already established within the health care. It is priority 1 through priority 7. Priority 1 group is 50 percent or greater, priority 2 is 30 or 40, priority 3 is former POWs, 10 or 20's or Purple Hearts. Those folks have a service connection. We have already established a system to determine whether they are eligible or not and set a priority group. I believe we should stick to it and not deal with the age issue.

Mr. OTTER. Great. Thanks, Mitch. Lee.

Mr. BEAN. I think age partly should be involved because of your ability to go out and make a living. If I have a good income to where I could go out to dinner once in a while and things like that, I wouldn't even be here. I wouldn't be asking for prescription drugs, and that is all I am asking for. And one of the reasons I am asking for that is I have a lot of friends who are getting these prescription drugs from other VA hospitals by walking in and getting them.

Mr. OTTER. My apologies for stopping you right there.

Mr. BEAN. OK.

Mr. OTTER. That is another question I am going to ask, and since you brought it up I want to ask you that now. If we had seen a successful conclusion of the house-passed Medicare drug benefit bill, which was $350 billion over 10-years, would you then seek access to your drugs through the Medicare program rather than through the VA program?

Mr. BEAN. I probably would, yes, because I am paying for health insurance right now, and the high cost of drugs is what is killing some of us; $55 a month for health care—supplemental health care in an HMO is not a big deal, but when you start paying a couple hundred dollars a month for two pills, it gets a little ridiculous.

Mr. OTTER. Thanks, Lee. Tom.

Mr. SMITH. I don't think that age should really play a factor in it. I think that any disability, any disabled vet should be—the care should be accessible for him. I agree with Mr. Bean that there is a lot of people out there that are getting medication that—I know some that are getting medication and Mr. Bean would be just as entitled to it as they are. I don't have anything further, I don't think.

Mr. JONES. I agree with the comments by the other panelists. I am concerned that it should be based upon their disability. My concern is that you have individuals who had degenerative conditions and other conditions that with such an undo waiting list, undo waiting time, their condition would deteriorate so significantly from the time that they attempted to enroll to the time that they would actually be seen by a physician and receiving care. I don't believe that this is correct.

Mr. OTTER. All right. Let me start with the entire panel again, and I will start with you first, Mr. Jones, because you brought it up in your testimony that you represented in Mr. Teague's place, you mentioned out-contracting or community contracting. Do you know that is now the practice in any other place in the United States where they actually have out-contracting within a Veterans' Administration region?

Mr. JONES. I am not aware, but I can find out and let you know very quickly.

Mr. OTTER. I think we will probably get some testimony from Mr. Tippets or Dr. Lee a little later on on that. How about you, Tom?

Mr. SMITH. Really, I don't know of any other place where they are contracting out. However, I do know that the VA here does contract some out to St. Luke's. I think I would like to see the heart care increase a little beyond that, because after a heart attack or anything it is important to get the treatment and know where you are at immediately.

Mr. OTTER. Tom, relative to your experience between Boise and Seattle and traveling back and forth from the operation, the six-way bypass that you had in Seattle, do you think you are——

Mr. SMITH. No, I had the six-way bypass here at St. Luke's.

Mr. OTTER. Oh, excuse me. I misunderstood. Was your—so you rehabilitation was actually right here in Boise in your home——

Mr. SMITH. Oh, yes.

Mr. OTTER [continuing]. Around your family.

Mr. SMITH. That is right.

Mr. OTTER. OK. Well, let me ask you the question anyway in a hypothetical sense. Do you believe that your healing process, that your rehab process was much faster as a result of being home within your own community and around your own surroundings than it would have been had you had to have that in Seattle?

Mr. SMITH. OK. Now, I can relate on that a little bit further here. After my heart attack I went to Seattle. I waited 5 days here for a bed in Seattle in the Cardiac Care Unit. I went to Seattle, and I came back—when I came back I was probably more distressed than I was before I left. The second time I went to Seattle and they did a skin implant and I came back, I was feeling better because the stint was pretty successful, and it is not a real invasive procedure. And I was feeling better and so recovery was probably good. But when I had the six-way bypass, if I would have had to travel from Seattle back to here after a six-way bypass, I don't know how I would have done it. It is just unbelievable to me that people do that. I don't know.

Mr. OTTER. OK. Lee.

Mr. BEAN. No. I have nothing to say about that. The only thing I was talking about age is that I think all service-connected veterans should all be first, No. 1. All I am talking about are medications. That is all I am talking about when it comes to age.

Mr. OTTER. OK. Thanks, Lee.

Mr. JAURENA. I know of no outsourcing. I haven't had any medical care here yet, so I can't talk intelligently about it.

Mr. OTTER. But in your testimony didn't you offer to us that your prescription that you got from your own doctor was initially filled through the VA facility?

Mr. JAURENA. No, it was not.

Mr. OTTER. Oh, I am sorry.

Mr. JAURENA. It was not. They will not fill the script here from a private physician. You must have a physician in the VA hospitals before they will fill the script here in the hospital. That is one of the things I find absurd.

Mr. OTTER. I see. I am sorry, Lee. I guess it was you, just one more question. Lee, I think it was you that said that your prescription which you received from your own doctor was eventually filled.

Mr. BEAN. Yes. I saw a physician's assistant, a nurse, and she looked me over. I didn't see a doctor, no, but I got my prescription for 1 year cutoff because I didn't see a doctor.

Mr. OTTER. Thank you, Mr. Chair.

Mr. SHAYS. Thank the gentleman. I am delighted that this committee is here, and I was thinking before we started that we talked about how the first hearings of the Supreme Court were wherever they could have a hearing, sometimes in taverns, and I just will note that while we are at a tavern of sorts, the bar is not open. [Laughter.]

And also to say that our perspectives are so different. I am a Yankee, grew up in New England area, and my constituents have some real complaints but they are a little different. I will just say as a side when I was in Whitefish, Montana with a close friend there were three cars coming in on a main street that we were trying to get on and my friend was driving, and I wanted to see how she had to react because she had to wait as one car went by, then

another car went by and then another car went by and then we got on the main thoroughfare, and she turned to me as she was driving and she said, "I hate traffic," and I was thinking, boy, you would have to wait for 30 cars before you could get on a main street where I live. And then I was thinking of distances and I was thinking, though, that my veterans, if they have to go 60 miles, consider that an outrage. And you all have to go the equivalent in my area where I live near New York of having to go up to Boston or to Columbus, Ohio, in one or two instances, to get the kind of service you need. So it is important that Members of Congress get exposed to these different perspectives, because ultimately we are looking for ways to write legislation that is going to meet the needs of the veterans but is flexible to the different groups.

My first question then relates to this. I will start with you. Are there any community-based health care clinics? For instance, in Connecticut, as small a State as we are, we are like a county here, we have one main facility in Westhaven which is kind of centrally located, at least between the north and the east and west, right on Long Island Sound, but we have about four community-based health clinics that our veterans can go to to get the kind of prescription services that you need, not to have a bypass but to go there. So are there any community-based health care clinics that you get to utilize?

Mr. JAURENA. There is, Mr. Congressman, there are several out here, but I have not used them so I can't speak intelligently about them. I don't even know where they are at yet, because I haven't had any appointment.

Mr. SHAYS. We will be able to ask the second panel about this.

Mr. JAURENA. I think Mr. Jones and down the line will know about them also.

Mr. SHAYS. But I would be anxious just to know if any of you—Mr. Smith, did it ever serve your need, or Mr. Bean, to go to a community-based health care clinic? Are they a big deal in this area or not that important?

Mr. SMITH. Not me.

Mr. SHAYS. OK.

Mr. SMITH. The only thing I have done was St. Luke's with the heart bypass.

Mr. SHAYS. Mr. Bean, did you have occasion to use a community-based health clinic as opposed to coming to the main facility?

Mr. BEAN. St. Luke's or St. Jones.

Mr. SHAYS. Yes, Mr. Jones; yes, sir.

Mr. JONES. Congressman Shays, there are three community-based outpatient clinics in Idaho: One in Pocatelo, which is I believe under the Salt Lake VAMC; one in Twin Falls, which is under the Boise VAMC; and one in Lewiston. The one in Lewiston is a part-time—part-time it opens. In all three, it is my understanding is that you still run into the same situation that there is a waiting list, and you would still need to go through the VA enrollment process to receive those services. It is unfortunate that recently, and I would have to look up the name, of the individual that had given a directive that we were to stop advertising the community-based outpatient clinics, and that has resulted in a lot of flack that she has received for that. But those are in existence and working

in discussions with the CARES Group there are discussions of additional community-based outreach clinics opening up, and I think it is a very appropriate outlet to reduce the pressure on the VAMCs.

Mr. SHAYS. The VA does a lot of things quite well, and one of the things, though, there had been this debate and I would—this may seem a little off the subject, but it would be helpful to know. I want to take advantage of knowing how you all would feel in this part of the country. There are some that argue, and I frankly took this argument but have backed off a little bit because of the response from the veterans, and that was that there are some who say why not give a veteran a card that notes that they are a veteran and let them go to any hospital in the country and get service? I am not going to tell you what the answers were of my veterans, I want to know what your answers are, and then I am going to respond to that. Colonel, we will again start with you. In other words, if you could get a card that said you are a veteran, you can go to any facility and you wouldn't have to just go to a veterans' facility, would you like to see that kind of system?

Mr. JAURENA. I run parallel. I have a card from DOD, it is called TriCare Prime. I can't get a doctor to take it because the Federal Government doesn't pay enough to those doctors and pays in such a poor manner and so late that they refuse to take it. I believe the same thing would roll with the VA system. I am in a system already that does that, and I wouldn't adhere to any other system that does the same thing. It doesn't get me care, so we need——

Mr. SHAYS. You would rather be treated in a VA facility.

Mr. JAURENA. I would rather be treated in a VA facility because our payments, I believe, will never keep up with what the civilian community is going to require, and they will not take us. I would even take it if we did and had a reasonable copayment, sure, but I don't believe we can keep up with it. The DOD can't keep up with it, I see no reason the VA can keep up with it.

Mr. SHAYS. Mr. Bean? You know what I think I am going to do, I am going to rotate so that way you can switch the microphone. We will go to you Mr. Smith, and then I will go to Mr. Bean. So the question is would you prefer to be treated in a veterans' facility or if you could have a card and go to the hospital in the Nation and prefer that?

Mr. SMITH. Well, right now I would say that the treatment at the VA center is excellent for what you get, and then I would like to stay with the VA system. However, it is terribly underfunded here and understaffed, and with the understaffing and underfunding, I am seeing a cardiologist right now on the outside because we don't have one on staff full-time here at Boise VA.

Mr. SHAYS. Well, you trigger a second question, and that is would you want to see a hybrid? In other words, if, for instance, at Boise they couldn't provide the cardiac type of health care that you needed, would you like to be able to go to a non-VA hospital and get that kind of care so you wouldn't have to go to Seattle to get the care that you needed?

Mr. SMITH. Yes.

Mr. SHAYS. OK. Mr. Bean.

Mr. BEAN. I don't think I really qualify because I am not disabled, I am not in full claims.

Mr. SHAYS. No, you qualify because you are a veteran and I want to know what you think as a veteran.

Mr. BEAN. I would just as soon use my Medicare and if the government can help with a supplemental insurance type thing go to the regular hospital because there are more available.

Mr. SHAYS. OK. Mr. Jones.

Mr. JONES. I would prefer to go to the VA medical center, but if services at that center were not available, I would prefer outsourcing within the community so that I wouldn't have to leave the community for service.

Mr. SHAYS. And let me just say that is kind of the way I should have said it. In other words, we outsourced it in the community.

Mr. JAURENA. Mr. Shays.

Mr. SHAYS. Yes.

Mr. JAURENA. Again, I would like to jump back in. Now that you have thrown a second one into the pile, absolutely, I would like to go to the VA and then if they could not provide those services, outsource it out for specialty care.

Mr. SHAYS. So you could be local.

Mr. JAURENA. I believe that system would work wonderfully.

Mr. SHAYS. I can't think of it being more difficult, Mr. Smith, than to go to—to have a major operation, I mean one that is one safe but a major operation and not be relative near your home, near your family, near your friends. So I have that sense.

Mr. SMITH. I just can't agree any more than what you said there. If you are not near your family, you are worrying about them, they are worrying about you, the whole situation is not good.

Mr. SHAYS. Now, let me just say to any veteran or anyone else who wants to testify, after we finish one or two, that question would be something I would be interested for you to address. The response from my veterans is they are afraid that if we get rid of the VA system, that ultimately the card will become meaningless, and they at least like to know they have got this pole in the ground that basically says this is a VA facility. Also, they feel that the VA facilities have a little more sensitivity to the illnesses of veterans but also to understanding their perspective. So the outsourcing, I think, probably would be more—my own constituents would be more inclined as long as they didn't see it replacing the VA facility.

Let me just—I have some questions that staff believes I need to put on the record, so let me just run through this as well, and we will start with you, Mr. Bean, since you have the—have you felt that a communication with the VA facility has been done in a professional way, and do you feel that you have always been kept informed by the VA when you have had requests out there?

Mr. BEAN. I don't feel like I have been kept informed, but any time I have called to talk to them they have been very nice, no problem there at all, but I have not been informed.

Mr. SHAYS. Mr. Smith.

Mr. SMITH. Yes. They have been very professional.

Mr. SHAYS. And they stay and keep you informed.

Mr. SMITH. And they keep me informed.

Mr. SHAYS. OK.

Mr. SMITH. The appointments are noted and mailed, and everything is—if I call with a question, it is answered. There is not any real problem there.

Mr. SHAYS. Colonel.

Mr. JAURENA. They have been very professional and very informative. Not only do they send an initial appointment letter, they send a reminder letter. So they have been very good. The level of care I can't talk about.

Mr. SHAYS. Let me just ask another question. When you go into the facility you have to wait to get there, but once you are there do you have long waits?

Mr. JAURENA. I can't talk to that. I walked in and registered and got my card, and they said, "Don't call us, we will call you."

Mr. SHAYS. Right. OK. So you are a work in process right now. Mr. Smith.

Mr. SMITH. There can be some long waits. As I noted, the lab is small for that size hospital. I feel there are not enough people in there. They can't get people through that need to be done. The pharmacy is a little bit of a bottleneck. It is better than it used to be, they are trying to improve things. It is the funding and the staffing.

Mr. SHAYS. I would just ask you to answer that question, Mr. Bean, and then, Mr. Jones, I will finish up with you.

Mr. BEAN. I was only there two times and each time I had to wait, oh, maybe half an hour, something like that, which was reasonable as far as I was concerned.

Mr. SHAYS. In my part of the country, veterans will sometimes literally wait half a day before they get—they come, they are told to get there, and they are queued up in big lines and so on. Source of tremendous disappointment. You know, they wait a long time to get there, and once they are there they wait.

One of the things I want to put on the record is that the VA has one of the best drug programs in the Nation, if not the best, because we buy in bulk and we pass on the savings, and the savings are considerable. And we are using the VA model as a way to look at Medicare, because Medicare purchases by the government are basically paid for individually at individual prices, not at bulk prices. Totally understandable why anyone who is needing drug assistance would go to the VA facility, because you pay a fraction of what your neighbor may pay if you are fortunate enough to get in that system. And I understand why, Mr. Bean, you would be working overtime to have that happen.

Mr. Jones, just in a—we need to get to the next panel so we need to move along, but let me just ask you this: Describe to me how the State VA facility interfaces with the Federal system as briefly as you can do that.

Mr. SMITH. Certainly. Let me just start off by saying they have been extremely professional. The Division of Veterans' Services in Idaho operates three State veterans' homes located around the State. Each of these veterans' homes is being serviced by a different VAMC, so I am able to relate and respond not only to the Boise VA but to the one in Spokane and the one in Salt Lake as well. In each case, they have been highly professional. The veterans' homes received a much greater level of service from the

VAMCs prior to the State-directed certification by Medicaid. Once they were certified by Medicaid, there were a number of services that had been previously available and provided by the VAMCs that were no longer available to the veterans who were residents within the veterans' homes. The VAMCs also operate long-term skilled facilities themselves, and that is certainly an issue that is being addressed by the Mill bill and some things like this. But a long story short, they have been very professional.

Mr. SHAYS. I would just note for the record that when we had a hearing in New York State about 2 hours north of the city, the room was packed. It was about a little smaller than this, it probably had about 300 people in it. And at one point, I was defending the VA, which was not the mood of the group, and a police officer came up to me and whispered in my ear, he said, "In case you have to leave early, there is a door in the back." And I just want to thank you for the fact I can go out the front door in this hearing. [Laughter.]

If there are no more—do you have any other questions?

Mr. OTTER. No, I have none.

Mr. SHAYS. Let me say that you all—your statements were really pertinent and ripe to the topics of the questions, so we had a number of questions to ask, but you answered them in the questions. So I just thank you for your participation, you have been wonderful witnesses, very helpful to the committee and we will go on to the next panel, unless there is just—I usually do this, I forgot to do this. Is there any closing comment that anyone on this panel would like to make? Yes, Mr. Smith.

Mr. SMITH. I would like to make one. There is just one statement I would like to make and that is the things that I have had here and everything are true, but the main thing that I would like to see is on heart care. I just hate to think about somebody laying up there for 5 days like I did the first time when I had the heart attack and then transferring to Seattle. Five days waiting to find out how much heart damage you have got is just unreasonable.

Mr. SHAYS. It is.

Mr. SMITH. And I would like to see something like that changed.

Mr. SHAYS. And I think both Mr. Otter and I would totally and completely agree with you. Probably some people in the VA would as well. So we are going to try to find a way to solve that problem.

Mr. SMITH. Thank you.

Mr. SHAYS. Any other comments? At this time, then, let me call Dr. Leslie Burger, Network Director, Veterans' Integrated Service Network, Department of Veterans' Affairs; accompanied by Mr. Wayne Tippets, Director of Boise Veterans' Administration Medical Center, Department of Veterans' Affairs; accompanied by Dr. David K. Lee, Chief of Staff, Boise Veterans' Administration Medical Center, Department of Veterans' Affairs.

Before I swear in the first panel, I do want to put in the record another witness who was going to be here, Rex T. Young, from Meridian, ID. Meridian, I am sorry, Meridian. And the part of the statement he said, "With all the emphasis on early detection and early treatment, it is not very comforting to be told by a doctor after an examination that I need to see a urologist and also need a colonoscopy and be told the urologists are making appointments

9 months out and having a colonoscopy appointment made 9 months out." He basically said the delay on seeing the urologist and obtaining a colonoscopy through the VA system could have life-threatening. He was in fact told to have one because there was a concern about his life. That is I think consistent with what we have heard in other places around the country and consistent with the panel. We will put this, without objection, his entire statement on the record.

[The prepared statement of Mr. Young follows:]

October 2, 2002

Subcommittee on National Security, Veterans Affairs, and International Relations

RE: Field Hearing on VA Health Care: Access Delayed, Access Denied

WRITTEN TESTIMONY

My name is Rex T. Young, resident at 2950 E. Victory Road, Meridian, Idaho 83642. I am a veteran with 40% disability and I have been receiving medical care at the Boise, Idaho, VA Medical Center since my retirement on January 31, 1995. I have been pleased with the medical treatment which I have received but have been extremely concerned with the delays in gaining treatment. The following is the actual situation which I have experienced:

I was assigned a new Doctor, Doctor Opie, and my first appointment with him was on October 25, 2001. I was informed that as a result of the prostate examination that I needed an updated PSA test, needed to see a Urologist, and needed a Colonoscopy. He told me that I should call in about one week if I had not heard any information on appointments and that they would also have the results of the PSA test. I called about one week later and was informed that my PSA had raised and that nothing had been done for an appointment with a Urologist but they were about 9 months out on appointments. They told me that if I wanted an appointment sooner that maybe I should make an appointment with a Urologist outside of VA. By VA letter dated October 30, 2001, I was informed that a Colonoscopy was scheduled for me on June 11, 2002 (approximately 8 months out).

With all of the emphasis on early detection and early treatment, it is not very comforting to be told by a Doctor after his examination that I need to see a Urologist and also need a Colonoscopy and be told that the Urologists are making appointments 9 months out and having a Colonoscopy appointment made 9 months out. As a result, I made appointments outside of VA for both procedures. Needless to say, getting those appointments without a referral was not an easy task. The latter part of November I received a letter from VA telling me that an appointment with a Urologist was scheduled for January 7, 2002. Both of those VA appointments (Urologist & Colonoscopy) were cancelled as I had made other arrangements.

During my examination by Doctor Opie in October 2001, I informed him that I was having increased problems with my vision and also my hearing. He told me that he would order a consult for me with both clinics. I had previously attempted to get an eye appointment in January 2001 but was told that they would place me on the waiting list.

When I called to check on the status of the consult that was ordered by Doctor Opie, they indicated that they had not made any appointments for new patients for over one year and it would at least 2 years before I could be seen. When I checked with the Audiology Clinic they informed me that they were at least a year out on appointments and that I was not even scheduled yet.

On January 24, 2002, I wrote a letter to the Director, VA Medical Center, outlining my concerns and asked for a response. On February 27, 2002, not having a response, I started telephone follow-up in an effort to get a response. On April 4, 2002, I asked for Congressional assistance and on April 6, 2002, a response was received (dated April 3). About a month later I was notified by VA that an Audiology appointment was scheduled on June 20,2002. I have not received and information from the Eye Clinic but have made appointments outside of VA and had Cataract surgery on both eyes.

As I indicated earlier in this letter, I am very satisfied with the medical treatment that I receive through VA but am very frustrated with the delays in obtaining treatment in some cases. The delay on seeing a Urologist and obtaining a Colonoscopy through the VA system could have been life threatening.

TESTIMONY OFFERED BY: REX T. YOUNG
2950 E. VICTORY ROAD
MERIDIAN, IDAHO 83642
Phone: 208 888-2230 FAX: 208 228-0095

Mr. SHAYS. He would have liked to have been here. I don't know if it is the hunting season and he is out hunting. Is that a possibility? I understand. OK.

If you would, please, rise before you. Raise your right hand. Thank you.

[Witnesses sworn.]

Mr. SHAYS. Note for the record our witnesses have responded in the affirmative, and we have one testimony. Our testimony is from you, Dr. Burger, but all three will respond to questions, if necessary.

Mr. BURGER. And we will all give some testimony too if you would permit.

Mr. SHAYS. Right. Oh, you all three want to give some? That is fine. Yes, that is fine. Let me ask you, though, I am going to ask you to hold that mic up but close enough so we can hear you.

Mr. BURGER. Usually I am pretty loud.

Mr. SHAYS. OK. Well, Dr. Burger, delighted that you are here. Thank you, and be happy to take your testimony.

STATEMENTS OF LESLIE BURGER, NETWORK DIRECTOR, VETERANS' INTEGRATED SERVICE NETWORK, DEPARTMENT OF VETERANS' AFFAIRS; WAYNE TIPPETS, DIRECTOR, BOISE VETERANS' ADMINISTRATION MEDICAL CENTER, DEPARTMENT OF VETERANS' AFFAIRS; AND DAVID K. LEE, CHIEF OF STAFF, BOISE VETERANS' ADMINISTRATION MEDICAL CENTER, DEPARTMENT OF VETERANS' AFFAIRS

Mr. BURGER. Thank you, sir. Mr. Chairman, members of the committee, on behalf of more than the 7,600 dedicated——

Mr. SHAYS. I am going to ask you to put the mic closer.

Mr. BURGER [continuing]. Employees at the eight facilities and 17 community-based outpatient clinics of VISN 20, the Northwest Network——

Mr. SHAYS. Tell me, the Northwest Network includes how many States?

Mr. BURGER. Four, Mr. Chairman: Alaska, Washington, Oregon and much of Idaho.

Mr. SHAYS. OK.

Mr. BURGER. We claim to be the—we encompass 23 percent of the geography of our great country, actually, and that does present, as you alluded to, one of the major issues that we have. Our facilities are several hundred miles apart, getting patients seen up in Anchorage, Alaska and so on and. The idea is our CBOCs, even though we have 17 CBOCs, they are still a considerable distance among all our facilities. It has been a major challenge for us.

Mr. SHAYS. Let me just parenthetically ask you, I know a lot of service men and women who have had the opportunity to serve in Alaska and then decided to retire there, so are you getting a fairly large population of veterans going to Alaska?

Mr. BURGER. Yes, sir. We serve between 10 and 15,000 veterans in Alaska and have opened a couple of CBOCs there and again have really challenges of getting people from Nome and Barrow and the Keeneye Peninsula and so on.

Mr. SHAYS. How many veterans total in the VISN 20?

Mr. BURGER. How many are living there?

Mr. SHAYS. You know what? Get on with your statement. I shouldn't get this—get right to your statement, please.

Mr. BURGER. We served 11,000 veterans this past year in Alaska.

Mr. SHAYS. OK.

Mr. BURGER. If I might, before I make the statement, to respond to a couple of the questions that were raised from panel one, just some data for you. We indeed do use contract care considerably in the network, and fee schedule, fee basis care. I have some data for that. Non-VA care amounted to over $76 million last year across our network. And I did comment to you about the CBOCs that now number 17. About half of those opened in the last few years.

My statement, since the inception of the Veterans Integrated Service Network some 7 years ago, our network has been a recognized leader in the quality of care it provides to veterans in the Northwest. Winner of several quality awards, we really are proud of the fact, as we heard from the first panel, that those veterans who use our services consistently rate us among the best in VHA in the patient satisfaction surveys that we do. And something that we are equally proud of is that our employees rate us very highly in employee satisfaction surveys. I have provided for you a copy of the Malcolm Baldrige National Quality Award application. We have been applying—have applied for the Malcolm Baldrige Award. A health care organization, private or public, has never won this award, and we are really pleased in how we are progressing in doing that. That really does speak to the quality of our organization.

Mr. SHAYS. Good luck.

Mr. BURGER. And as you have heard here from the first panel, with the passage of eligibility reform and the opening of several CBOCs across our network, our veteran users have grown some 32 percent, from 125,000 in 1997 to approximately 165,000 this past year. This represents an overall market share of about 17 percent of the more than 1 million veterans that live in our network catchment area.

We have consistently served the highest percentage of priority 1 through 6 veterans in VHA, and that accounts for about 82 percent of our workload. We are No. 1 in VHA in serving priority 1 through 6 veterans. Our market share of service-connected and low-income veterans in our area is 33 percent. I would point out to you, Mr. Chairman, that with approximately 30 percent of our patients being age 65 or older, we are one of the youngest networks, demographically speaking, and we will face many of the issues that you face back east in the next decade or so as our veterans age.

Mr. SHAYS. I am going to ask you to put the mic a little closer. See, we hear you all right, but I just want to make sure.

Mr. BURGER. OK. Maintaining high quality and increasing productivity has been achieved in no small measure by dramatic shifts from in-patient care to ambulatory care and from acute episodic care to a patient-focused primary care and disease prevention strategy. There have been many innovative practices that have allowed us to drive down or otherwise control increased costs in laboratory and pharmacy and radiology. We have adopted changes in care delivery to include such things as group visits, the use of more structured telephone followup care, by establishing a 24 by 7 tele-

phone care system for our, by improving patient flow in clinical areas and advanced telemedicine to deliver patient care and other staff activities and advanced clinic access for appointing. These are some of the many practices that have really changed the health care delivery landscape for us and helped us to provide more and more care more efficiently for our veterans. Each of these innovations is really patient-focused, designed to empower our veterans as well as to improve our efficiency.

Speaking to budget for a moment, approximately 96 percent of our network's budget is allocated through the Veterans Equity Resource Allocation model, the VERA model. This distribution formula takes into account workload, patient complexity and other local factors. Without sizable increase in workload over the past several years, our network has fared fairly well in this distribution process, receiving more funds percentage-wise than the national average in all but one of the last 6 years.

I have provided an attachment in the testimony that really speaks to the marked increase in the numbers of patients that we have taken care of, while at the same time we have been able to hold down the costs for veterans served, which is really a tribute to the staff and being able to accomplish that.

Until recently, we have been able to keep pace with these demands for services, but as you know with the economic downturn here in the Northwest, unemployment is one of the highest in the country. As of a couple of weeks ago by looking at the Bureau of Labor and Statistics Web site, Alaska was 51st in unemployment, highest unemployment in the country, Washington State was 50th, Oregon was 49th, Idaho was 30th. So unemployment is a major issue for us here in the Northwest. The States of Washington and Oregon have been heavily penetrated by health maintenance organizations, and over the last couple of years some of these health maintenance organizations have dropped coverage on thousands and thousands of beneficiaries, many of whom are veterans.

I would also point out that health care inflation is at least twice the overall inflation rate, and the growing cost of medication, which is up some 15 to 19 percent these past couple of years, and a shortage of health care workers all together have made it such that the demand for health care services have now exceeded our ability to provide those services.

The backlog, as you have heard from the first panel, patients waiting for their first appointment and those waiting for more than 30 days for appointments has dramatically increased. I would point out that this is a very dynamic waiting list. Every month, hundreds and hundreds of people are taken off the waiting list and there are hundreds and hundreds more people that are placed on the waiting list.

Mr. SHAYS. Yes. The tragedy, though, is in order to get service, sometimes you are waiting for someone to die.

Mr. BURGER. I would comment to that, sir, and that is that as our veterans enroll we are now using a questionnaire, so our veterans are asked about their health status and what it is they are actually seeking from us. We are trying to find those veterans who have a medical acute need, and we are placing those folks, trying to give them appointments right away.

Mr. SHAYS. No, but I am not trying to incite here, I am just trying to suggest not that we are denying someone services who is about to die, but in order for a veteran to get service he has to sometimes wait, or she, but has to sometimes to wait for people to literally pass away so that they are then on that list, and that is a challenge for us.

Mr. BURGER. OK. Another comment to that, it turns out that about 25 or 30 percent of our veterans turn over every year. Many of those——

Mr. SHAYS. I want the definition of turnover.

Mr. BURGER. Many veterans come to us for a single purpose—single visit for a single purpose. They don't come back by their choice. Other veterans indeed to pass on, and another group of veterans actually are transient, they are no longer living here. And that really accounts for most of that 25 percent turnover. I point this out to mean that of the 165,000 veterans that we have served this year, that means that 40,000 of those we did not serve last year and we have taken on, in addition to that, another 9,000. We have increased about 5 percent over last year. So of that 165,000 veterans, about 49,000 of them did not come to us for care last year. So it is a very dynamic process. But even so we are not keeping up. There are more people coming on that list than we are capable of taking off that list.

We have taken many measures to cope with this increased demand. I mentioned that we are querying people at the enrollment process so if there is medical circumstances that require it, we give people appointments quickly. We have expanded clinic hours, we have increased our patient panel size to 1,000 to 1,200 patients for each of our primary care providers, we have applied supplemental funding that the Congress has given us, we have begun the process of expanding our ability to provide primary and specialty care with that money. In the past 2 months, our waiting list for primary and specialty care across our network has decreased more than 20 percent. It was as high as 30,000. It is currently well under 23,000. And Mr. Tippets and Dr. Lee will address Boise specifically about that. On October 1, we did institute a plan to give priority for appointments to veterans with 50 percent or greater service-connected disability. We have begun to contact those veterans by phone and by mail.

We have taken a balanced approach now with the additional resources that have been provided in order to meet the full spectrum of the needs of our veterans. That includes primary care, specialty care, long-term care and to meet the dramatic increased demand for compensation and p pension examinations. We can't do one without the other. These are all connected, and we are trying to do this in a balanced way. We have tried to craft a plan that will be sustainable by bringing on some new staff, by calling on our affiliated universities to assist, by contracting for some services and using fee schedule for others.

I would emphasize to the committee, as you pointed out, that the application of supplemental funding is a temporary solution for us. With this year's budget, we will not be able to sustain a large number of—the increase that we have taken on and sustain these services next year. For this reason, there is a hesitancy for us to hire

employees as the sole means of dealing with this increased demand.

Mr. SHAYS. Let me just ask a question. Your compatriots are also going to testify. It is 10 minutes now, I did interrupt you a few times here. How much longer do you think you need?

Mr. BURGER. I have just a closing comment.

Mr. SHAYS. OK.

Mr. BURGER. I just wanted to summarize by saying we have been a consistent leader in VHA and the quality of care that we are providing, and in spite of the many efforts we are putting forth to provide care efficiently and effectively, including the increase in resources we have been given, we really have come to a point where the demand has far exceeded our ability to do that. We are assuring that patients with acute medical needs are having those needs met. We are getting priority to veterans with 50 percent or greater service connection, and we do anticipate in the very near future giving priority for others for their service-connected conditions. Thank you very much.

[The prepared statement of Mr. Burger follows:]

Statement of Leslie Burger, MD, FACP
Network Director, VISN 20
Before the House Committee on Government Reform
Subcommittee on National Security, Veterans Affairs and International Relations Hearing on Access to Care and Quality of Care at the Boise VA Medical Center

October 15, 2002
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Mr. Chairman and members of the Subcommittee,

On behalf of the more than 7,600 dedicated employees at the 8 facilities and 17 Community Based Outpatient Clinics of VISN 20, the Northwest Network, encompassing the states of Alaska, Washington, Oregon, and much of Idaho, thank you for the opportunity to speak with you today. With me is Mr. Wayne Tippets, the director of the Boise VAMC and Dr. David K. Lee, Chief of Staff of the Boise VAMC.

Since the inception of the Veterans Integrated Service Networks some seven years ago, VISN 20 has been a recognized leader in the quality of care it provides to veterans in the northwest. The network won the Veterans Health Administration Quality Grant Award two years in a row (1999 and 2000), and last year (2001) became only the second network to receive accreditation as a network from the Joint Commission on the Accreditation of Health Care Organizations, attaining a score of 99 out of 100. Continuing our quest for excellence, we have been pursuing the prestigious Malcolm Baldrige Award, never won by a health care organization, private or public. In only our second year of applying for this recognition, VISN 20 reached the consensus stage in the process, of which we are justly proud. I have provided a copy of our application for the members and trust that you will be impressed with the outstanding results the network staff has achieved in each of the seven areas of concentration of the Baldrige process. In the organizational performance results section, you can see that we have been national leaders in preventive health care and disease management, performing well above standards established by Medicare and others in the health care industry. On inpatient and outpatient satisfaction surveys, our patients consistently rank us among the best in VHA. Likewise, repeatedly, on employee satisfaction surveys, VISN 20 has been a benchmark organization.

This quality performance has been maintained and improved while we have dramatically increasing our workload. Since the passage of eligibility reform, and the opening of several CBOCs across the network, VISN 20 veteran users have grown some 32% from around 125,000 in 1997 to over 165,000 (see attachment B), which represents an overall market share of 17% of the more than 1 million veterans living in our network catchment area. The growth in the numbers of

veterans served is even more remarkable in that, from year to year and across our facilities, 25-30% of the veterans we serve do not return the following year. This occurs for several reasons. Some come to us for a specific episode of care, and do not wish further health care from us. Others no longer live in our area. Still others have died. I point this out to explain the dynamic that each year, our network must take in 40,000 new patients just to maintain the current number of patients. Our "growth of 5%" this fiscal year actually represents 40,000 + 9,000 new patients, a remarkable accomplishment by the devoted men and women of the northwest network. We have, in addition, consistently served the highest percentage of Priority 1-6 veterans in VHA, which makes up 82% of our workload. Our market share of service connected and low income veterans in our area is 33%. With approximately 30% of our patients age 65 and older, our network is one of the youngest, demographically speaking, in VHA, and we will face the issues of a growing geriatric population in the next decade.

Given the modest increases in our resources over the past few years, maintaining high quality care and increasing productivity has been achieved, in no small measure, by the dramatic shifts from inpatient care to ambulatory care, and from acute, episodic care to a patient focused, primary care and disease prevention strategy. Innovative practices have allowed us to drive down or otherwise control the increase in the costs of laboratory, radiology, and pharmacy services. Adopting changes in care delivery, to include such things as group visits, which patients like, the use of more structured telephone follow up, establishing a 24 by 7 telephone center for patients to access, improving patient flow in clinical areas, the use of telemedicine to deliver patient care and for staff activities, and advanced clinical access for appointing, are some of the many practices that have changed the health care delivery landscape. Each of these innovations is patient focused, designed to empower the veteran, as well as to improve efficiency. We are currently one of the few networks exploring putting the patient's record on a secure website so the patient can have direct access to it. Eventually, the patient will be able to communicate with his/her provider using this modality.

Approximately 96% of VISN 20's budget is allocated through the Veterans Equity Resource Allocation (VERA) model. The distribution formula takes into account workload, patient complexity, and other local factors. With our sizeable increase in workload over the past several years, VISN 20 has faired well in this distribution process, receiving more funds, percentage wise, than the national average in all but one of the past six years. Coupled with the efficiencies described, the network, until recently, had been able to keep pace with the demand for services.

There are other factors that contribute to the erosion of the buying power of our health care dollars. Health care inflation, in general, has continued to exceed overall inflation by a factor of 2. In particular, pharmaceutical costs have risen by 15-19% in each of the past few years, due not only to inflation, but to the high

cost of newer medications, and the marked increase in the number of drugs patients take. There is, in addition, a shortage of health care workers in many areas- physicians, nurses, pharmacists, radiology technicians, licensed practical nurses, medical technologists, to name but a few- that has driven up personnel costs far beyond the pay raises that are given to federal employees each year. Contracting for health services is, in the short term, very expensive, and providing incentives such as recruiting and retention bonuses, and the like, for our employees, while appropriate and necessary, are likewise costly.

Even before the tragic events of September 11th one year ago, the economy in the northwest began to experience a downturn. That downturn has persisted, and in the most recent figures released, unemployment in the northwest has been the highest in the nation (Alaska 51st at 7.3%, Washington 50th at 7.2%, Oregon 49th at 7.0%, and Idaho 30th at 5.3%). In addition, in Washington and Oregon, where there has traditionally been high penetration of managed care, several Medicare and other HMOs have declined to continue health coverage for tens of thousands of citizens. Both of these factors have undoubtedly contributed significantly to the growing demand for health services from the veteran population in the northwest.

As a result, and despite the Herculean efforts of the staff, the demand for health care services has overwhelmed our ability to provide those services. The backlog- patients waiting for their first appointment, and those waiting longer than 30 days for appointments- has dramatically increased. Waiting lists are dynamic, each month hundreds of patients being accommodated and removed from the list, while hundreds more are added to the list of those waiting for primary care and/or specialty services. Every one of our facilities in the four states we serve is experiencing this increased demand for services.

We have taken several measures to cope with this increased demand. In an effort to assure care for those with the most pressing medical needs, veterans are queried as part of the enrollment process, and when the medical circumstances require it, appointments are given. By expanding clinic hours, increasing the patient panel size to 1,000-1,200 patients for primary care providers, and applying the supplemental funding provided by the Congress, we have begun the process of expanding our ability to provide primary and specialty care. In the past two months the waiting list for primary and specialty care in VISN 20 has decreased by more than 20%, and is now at 23,187 (Anchorage 832; Boise 6,827; Portland 2,587; Roseburg 1,729; Puget Sound 4,050; Spokane 4,515; Walla Walla 1,712; White City 935). On October 1st, we instituted a plan to give priority for appointments to veterans with 50% or greater service connected disability. We have begun to contact them by phone or mail.

We have taken a balanced approach with the additional resources that have been provided, in order to meet the full spectrum of needs of our patients- primary care, specialty care, long term care, and to meet the dramatically

increased demand for compensation and pension examinations. We have tried to craft a plan that will be sustainable by bringing on some new staff, calling upon our affiliated universities to assist, contracting for some services, and using fee schedule for other services. I would emphasize to the committee that the application of supplemental funding is a temporary solution. With this year's budget, we won't be able to sustain this level of services next year. For this reason, there is a hesitancy to hire new employees as the sole means of accommodating the increased demand for health services.

In summary, VISN 20 has been a consistent leader in VHA in the quality of care it provides. In spite of the many efforts put forth to provide care efficiently and effectively, and the increase in resources we have been given, we have come to a point where the demand for health services has exceeded our ability to provide such services. We are assuring that those patients with acute medical needs are having those needs met, are giving priority to those veterans who have 50% or greater service connection, and anticipate, in the very near future, giving priority for others for their service connected conditions.

Thank you again for the opportunity to share these thoughts with you. We appreciate your continued support of our efforts to serve America's heroes. With your permission, I would like to ask Mr. Tippets to make some comments.

Boise VA Medical Center

The Boise VA Medical Center is a 46-bed facility with an adjacent 41-bed nursing home serving a Primary Service Area (PSA) with a radius of approximately 160 miles. The Boise VA Medical Center also operates a Community Based Outpatient Clinic (CBOC) in Twin Falls Idaho. The PSA of the Boise VA Medical Center covers a service area with a veteran population of 70,000 and includes 23 counties in Southwestern and Central Idaho and four counties in Southeastern Oregon.

Affiliated with the University of Washington School of Medicine, the Boise VA Medical Center medical staff is extensively integrated with the Southwestern Idaho medical community. The medical education program is composed of 15 full-time faculty members, 52 consulting clinical faculty members, 20 residents in medicine, three to five physicians doing post residency work, and up to 10 medical students at any one time in medical clerkships. Other major affiliations include the Idaho State University College of Pharmacy and Boise State University School of Nursing.

Research plays a vital role in VHA and at the Boise VA Medical Center where a growing team of scientists conduct internationally renowned research in clinical pharmacology, gerontology, and pulmonary and infectious diseases. The fiscal

year 2002 research budget totaled $1.5 million dollars and included funds from both government and non-government sources.

Services Provided

The Boise VA Medical Center provides acute and intensive care, inpatient medicine, surgery and psychiatry services. Other programs include the Twin Falls CBOC, a mental health clinic, PTSD treatment team, alcohol and drug treatment program, audiology and speech pathology, respiratory care, oncology, ophthalmology, optometry, dental, radiology, nuclear medicine, physical medicine and rehabilitation, prosthetics and sensory aids, and social work services.

The Boise VA Medical Center is tied closely to the healthcare community in Boise and the surrounding area. Through the use of contracts, medical school affiliation, and the VA consultant program, more than 80 professionals from the community provide services to veterans at the VA Medical Center. A sampling of the specialty services provided by these community professionals include; oncology, neurology, dermatology, rheumatology, endocrinology, urology, orthopedics, and, neurosurgery.

The VHA is a comprehensive, integrated healthcare delivery system. The Boise VA Medical Center makes use of the comprehensive nature of the VHA by making referrals to tertiary care facilities where patients are able to receive state-of-the-art care that would not otherwise be available at the Boise VA Medical Center. In fiscal year 2002, approximately 600 patients have been referred to tertiary care facilities in Seattle and Portland.

Access

With much of the Boise VAMC service area located in rural areas, access to care has been, and continues to be an important issue for the Veterans we serve. The Boise VA has developed a number of programs to improve accessibility for our patients, including a CBOC, a Home Based Primary Care (HBPC) program and a DAV van service program.

The Boise VA Medical planned for and opened a CBOC in Twin Falls in June of 2000 to provide services to the 10,000 veterans that live in the five county area surrounding Twin Falls. Since opening the clinic, we have constructed and moved into a new 4,200 square foot clinic space and increased staffing levels in an attempt to keep up with growing demand for services. Currently we are providing care to approximately 1,500 veterans from the Magic Valley and we are recruiting for a full time physician.

Home Based Primary Care (HBPC) is another example of a program designed to improve access to care. Through the use of contracted home health professionals, the Boise VA Medical Center home health program is able to arrange and coordinate the care of veterans in even the remote areas of the Boise VA service area. The HBPC program is a proven cost effective program for delivering health care and it has been extremely well received by patients who appreciate receiving healthcare services in their own homes.

VA staff, working with the Disabled American Veterans (DAV) service organization, coordinate the efforts of a fleet of transport vans and private vehicles used to shuttle patients to and from outpatient appointments. In the last 12-month period, the DAV van program has logged over 278,000 miles and transported over 7,600 veterans to appointments at the Medical Center.

Workload and Funding

Over the past 5 years, the number of patients seeking care at the Boise VA has increased dramatically. Economic conditions, high quality care at the Boise VAMC, improved access, eligibility reform, and the changing demographics of the Pacific Northwest have all contributed to workload increases that have strained our ability to provide services. The Boise VA Medical Center has experienced an increase in the number of patients treated from 10,654 in FY 97 to 15,329 in FY 02, an increase of 44%. During this same time, outpatient visits have increased from 99,000 in FY 97 to over 155,000 in FY 02, an increase of over 57%. Appropriated funding for the care of veterans during this time period has not kept pace with workload. The graph in **attachment A** shows that during the time frame mentioned, the funding per patient (unique veteran) has fallen from $4,895 in FY 97 to $4,489 in FY 02, a decrease of almost 8% (constant dollars – not adjusted for inflation).

Waiting List

The increasing demand for care has required that we establish a waiting list system to ensure equity of access. Currently the Boise VAMC has a waiting list for primary care of approximately 3,600 veterans (1,785 priority 1-5 & 1,811 priority 6-7) and the Twin Falls CBOC has a waiting list of approximately 800 veterans (367 priority 1-5 & 436 priority 7). We have developed a process to assess clinical needs to ensure that we give priority care to veterans who are very ill and without other health care resources.

To begin to address the waiting list and backlog of workload, and resulting from a $142 million supplement passed by Congress, VISN 20 provided the Boise VA Medical Center with $1,000,000 in supplemental funding. This funding has been well received and deployed in a number of ways to address access problems.

On a short-term basis, this funding has been used to hire a temporary physician assistant who immediately began taking patients of the waiting list. To help address longer-term issues, we have hired a permanent physician assistant to work in Boise and have started recruitment for a second permanent physician assistant for Boise and a full time permanent physician to work at the CBOC in Twin Falls.

The supplemental VISN funding has also been used to address extended waiting times in many of our specialty service clinics. By increasing contract/consultant funding at the Boise VAMC, we have been successful in increasing the volume of procedures and services we buy from our consultant medical staff. The table that follows is an up-to-date listing of services provided and patients treated resulting from the supplemental funding.

Program or Specialty	Service provided	Number of Patients Treated
Orthopedics	Hand clinic and Surgeries	54
Orthopedics	Joint Replacement	11
Ophthalmology	Cataract Screens & Surgery	151
Ophthalmology	Diabetic Eye Exams	79
Urology	Urology Clinics	194
Audiology	Audiology Exams	182
ENT	Outpatient Clinics & Surgery	36
Comp & Pension	Additional Exams	40
Cardiology	Pmibi Heart Studies	20

The Boise VA Medical Center is not facing the waiting list dilemma alone. Every facility in VISN 20 has been dealing with this issue including Walla Walla and Spokane, the two other medical centers that provide primary care to Idaho veterans. Walla Walla VA has utilized supplemental funding from the VISN to hire a temporary physician who has been used to directly reduce their waiting list. Funding has also been used by Walla Walla to hire additional C&P capacity, freeing staff to begin reducing the waiting list. The Spokane VA utilized additional VISN funding to hire additional providers and increase the hours of contract providers to increase the number of primary care appointment slots and thus reducing their waiting list. Spokane also utilized the additional funding to purchase specialty services in the community including audiology, podiatry, ophthalmology, dermatology, cardiology and urology.

Patient and Staff Satisfaction

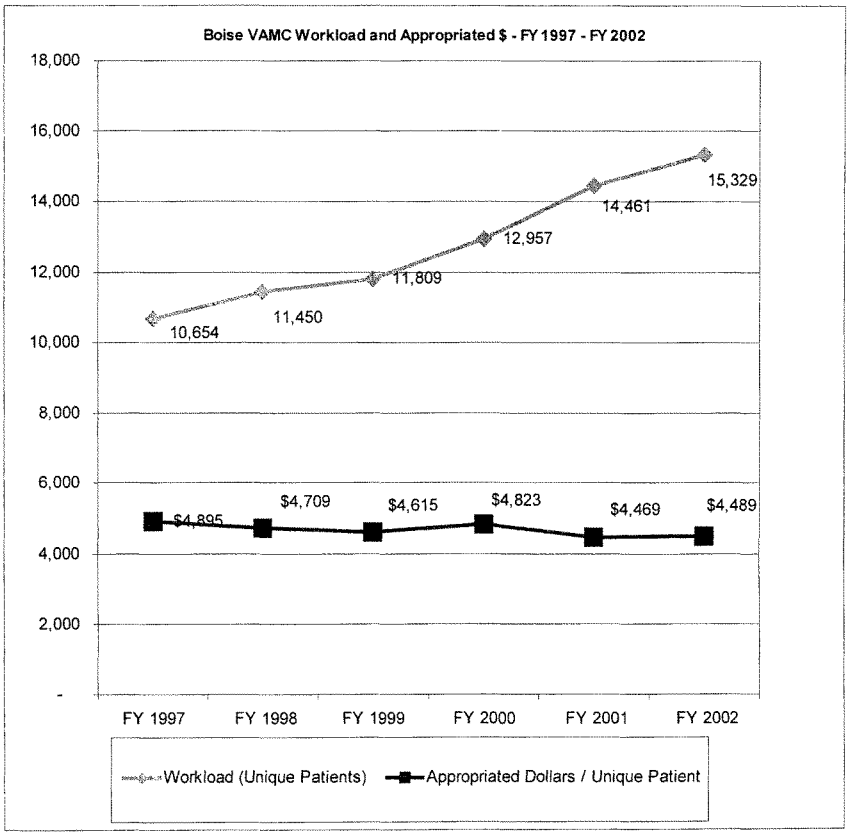
Staff at the Boise VA Medical Center take great pride in meeting the needs of the veteran patient. This pride is evidenced by the results of the fiscal year 2002 outpatient satisfaction survey administered nationally to over 45,000 veterans by the VA National Customer Feedback Center. Locally, the Boise VA Medical Center patients who were surveyed rated the Boise VA as a "center of excellence" (defined as a score 2 standard errors better than the national average) in 4 of the 11 survey categories, including the category of Overall Quality.

Staff at the Boise VA Medical Center also rate the Medical Center as a desirable place to work, and the VA as an "employer of choice". In the "VHA All Employee Survey" conducted in December, 2001, the Boise VA scored better than the national VA average in all categories and had the highest scores in VISN 20 (Northwest Network) in 14 of 18 categories, including, Overall Satisfaction, Overall Quality, Customer Service and Intentions to Stay.

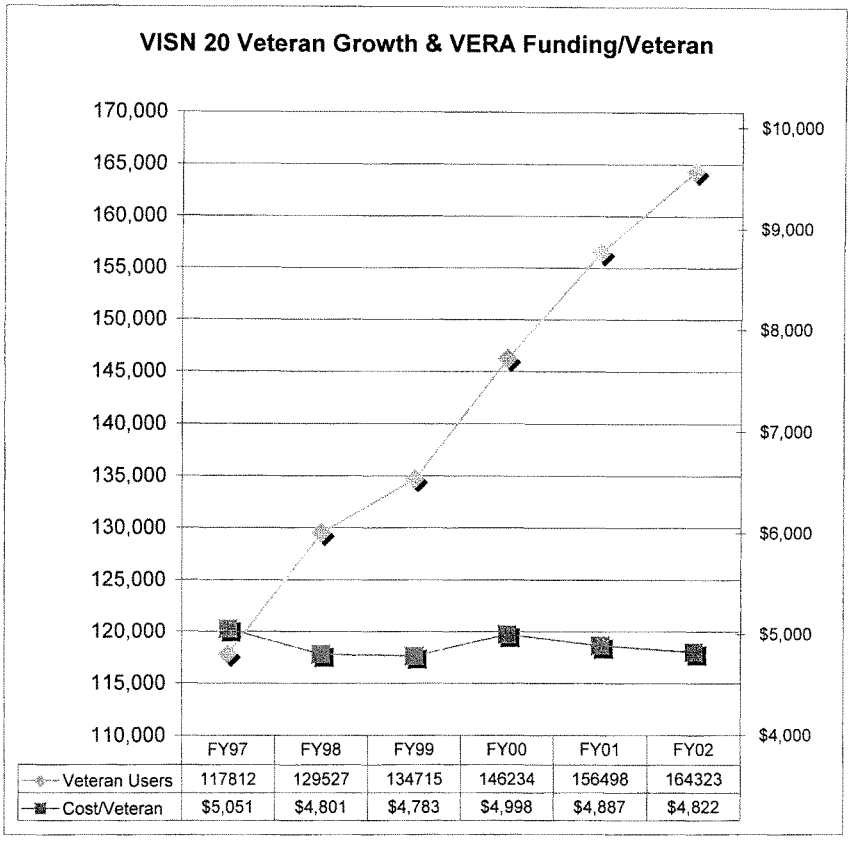
Conclusion

I am extremely proud of the quality of healthcare provided, and the employees who provide this care at the Boise VA Medical Center. There are many unique characteristics of the Boise VA Medical Center that have convinced me that it is one of the best VA Medical Centers in the country. Growth in the demand for services is one of many challenges facing us now. We are working to address these challenges and we will continue to work to be the provider of choice for our patients and an employer of choice for our employees.

Attachment A



Attachment B



	FY97	FY98	FY99	FY00	FY01	FY02
Veteran Users	117812	129527	134715	146234	156498	164323
Cost/Veteran	$5,051	$4,801	$4,783	$4,998	$4,887	$4,822

Mr. SHAYS. Dr. Burger, you would have easily finished within the 10 minutes had I not interrupted you. And also I think both Butch and I—Congressman Otter and I would want you to know is that we do know demand exceeds supply, so we are not coming here asking why you are not able to do all the things we want you to do. We have to provide you the resources to do it. Also, just say for the record, we have 600—we are increasing the number of veterans who are served nationwide about 600,000 a year. So we are trying to get more, but there is more than 600,000 that need help, particularly because of our drug benefit. We have got a lot of new customers.

Mr. OTTER. Mr. Chairman, if I may note for the record——

Mr. SHAYS. Sure.

Mr. OTTER [continuing]. Dr. Burger, your entire statement in its entirety, and having read that it is very informative, will be submitted for the permanent record.

Mr. SHAYS. Absolutely.

Mr. BURGER. Thank you.

Mr. SHAYS. And also to say that I don't know which of you gentlemen, Mr. Lee or Mr. Tippets, should go next.

Mr. TIPPETS. I will go.

Mr. SHAYS. Yes. Thank you, Mr. Tippets.

Mr. TIPPETS. Chairman Shays, Congressman Otter——

Mr. SHAYS. Is that mic on? Yes.

Mr. TIPPETS. Chairman Shays, Congressman Otter, it is my privilege to make a few remarks regarding the patient care at the Boise VA Medical Center. Just briefly, I will discuss workload, access to care, the current waiting list and the use of supplemental funds to decrease the waiting list. If I could refer you to page 9 of the written testimony, attachment A. In fiscal year 1997, we treated 10,654 patients; in fiscal year 2002, which just ended, that has increased to 15,329 patients. That is an increase of 44 percent. In fiscal year 1997, we had 99,000 outpatient visits; in fiscal year 2002, that has increased to 155,000 outpatient visits. That is an increase of 57 percent. During this same time period, funding per patient has fallen from $4,895 per patient to $4,489 per patient. That is a decrease of 8 percent in funding over that time period in spite of the workload going up.

Mr. SHAYS. Give me the time period again.

Mr. TIPPETS. 1997 to 2002, for 5 years.

Mr. SHAYS. So you have less per patient today than you had 5 years ago.

Mr. TIPPETS. Yes, sir.

Mr. OTTER. By 400 bucks.

Mr. TIPPETS. Yes. About 8 percent less.

Mr. SHAYS. And if you then equate to increased costs, then the number would be even——

Mr. TIPPETS. If you—yes. We did not do this on this attachment, but if you actually put in the medical inflation, that figure goes down to $3,500 or $3,600 per patient, yes.

Access. During that time period, we have opened a CBOC in Twin Falls, which is approximately 120 miles east of here. We staff that CBOC with two physician's assistants, two nurses, three clerks and a mental health provider. Each one of the physician's

assistants treat about 800 patients. We currently have a waiting list of about 800 patients at that CBOC. We are actively recruiting a physician and during the last couple of months have been interviewing. We think we might have a physician to go to Twin Falls. If we do, that should eliminate that waiting list at Twin Falls CBOC. At least right now it would eliminate it, but the waiting list will grow again.

At the Boise Hospital, we currently have a waiting list of about 3,600 veterans that are waiting for primary care appointments, and that is broken out approximately into 50 percent category 1 through 6 and 50 percent category 7s. And like I said, the Twin Falls CBOC has approximately 800 patients on their waiting list. With the new directive, if a priority 1 service-connected veteran walks in the hospital, that individual gets an appointment within 30 days. We have approximately 200 service-connected veterans, 50 percent and over, that are on our waiting list. We have, I believe, scheduled half of those people, and we are in the process of scheduling the other half for appointments, so that is being taken care fairly rapidly.

Let me talk a little bit about supplemental funds. In the fourth quarter of 2002, Congress passed supplemental funds to the Veterans' Administration in the amount of $142 million. As a result of that, this hospital got approximately $1 million. And I would like to tell you what we have done with that money. If you look at primary care, we have hired two physician's assistants. Each one of those physician's assistants will take approximately 800 patients. And we are in the process of recruiting for a physician at the Twin Falls CBOC, which, like I said, should eliminate the 800-patient waiting list there.

We feed in the community about 65 procedures in orthopaedics. These are patients that are on the waiting list. We also did about 150 patients that needed cataracts surgery, that was feed in the community. We took care of about 194 patients in the urology clinic. These are patients that either needed clinic appointments or surgery. We took care of about 182 patients for audiology exams and we increased EMT to take care of about 36 patients that either needed clinic appointments or surgery. So these funds were used to reduce the waiting list by feeding out most of the care to community providers. In order to continue this, of course, the supplemental funds need to be recurring or we will have to—we will not be able to do that.

I am going to stop there, and those are all the comments I have. Thank you very much.

Mr. SHAYS. Thank you, Mr. Tippets. Dr. Lee. I understand, Dr. Burger, you are also a Major General.

Mr. BURGER. Yes, sir.

Mr. SHAYS. Yes. Hard to know which——

Mr. BURGER. Retired, sir.

Mr. SHAYS. Retired. OK.

Mr. LEE. Chairman Shays, Congressman Otter, it is indeed my honor as well to be able to testify to your committee. I just wanted to comment on a few clinical issues as a physician beyond the data that you have already heard from my colleagues. One that I think has already been made a matter of the record but just to empha-

size it is that the waiting lists really are a matter of operational necessity, and we have heard that the high quality of care once you start receiving care is good and appreciated, and we value that. But the reason we can keep that quality high is because we do have to have the waiting lists in order to constrain the workload to something that can be manageable. It is a highly regrettable situation, however, and one thing I would like to say on behalf of the providers is that most of us went into health care because we were driven to help people. Most of us went into veterans health care because we love taking care of our veterans. And so it is very difficult and in fact even a bit corrosive, I think, at times for our providers to face veterans who have legitimate needs and not be able to meet them. So the voice in the face of the provider, I think, is something else that we should put on the table here.

And then we heard eloquently, I think, from panel one the human cost to many of the patients. With a supplemental funding that Mr. Tippets alluded to earlier, I had a real chance to kind of experience up close and personal many of the people on the waiting list. And in fact probably about 90 percent of the people that we took off toward the end of the last fiscal year with the supplemental funding indeed wanted their medications. But some of those were heartrending stories of people whose medication bills exceeded their Social Security monthly income.

And in addition to that, I wouldn't want it to be said that many of these people didn't have fairly serious health care needs. And just to paint that I saw two patients, one of whom had very uncontrolled hypertension, and in fact I would characterize as a stroke waiting to happen, and another patient who had gangrenous foot that we had to put in for a rather urgent vascular surgery. So there are many people on that waiting list with rather urgent health care needs that are not being met, and of course there is a very real human cost to that. I would be happy to respond to any questions, but I wanted to put a human face to those things.

One last thing, since I have the opportunity, is that Mr. Smith, I think, raised a very good point, which is a policy issue. And that is many years ago we were able to use VA funds to copay Medicare or private insurance, but there is a general council opinion that we cannot copay Medicare, and I am told that general council opinions have the force of law. And there is a VA regulation that says we cannot copay private insurance. And so for those two reasons, we are sometimes I think restricted unreasonably from being able to provide local care while local specialty care might be available through one of those two mechanisms. And that is a policy that I would think that you gentleman could change. Thank you.

Mr. SHAYS. Appreciate the testimony of all three of you and we will also thank all three of you for going the usual protocol, which is the government official goes first and then the so-called general witnesses go after. We have in this committee learned that it is very important to have the human face go first, and you touched on it, Dr. Lee, and you listened, all of you did, which is what we like, because then you can comment on that human face as you have already begun to have done. So I do want to thank you, though, because it is not a slight, it is just wanting to make sure

that we have—you get the point. I don't have to go on. Congressman Otter.

Mr. OTTER. Thank you, Mr. Chairman. I guess I will start with you, Dr. Burger. In your region, has the reduction in cost per patient, is that fairly representative of what has happened in the entire region of what Mr. Tippets and Dr. Lee have had experience in Idaho? It seems to me there are $406 reduction in 5 years not adjusted for inflation. Is that pretty representative of the entire region? Take your time.

Mr. BURGER. I believe it is, Congressman Otter. If you look in attachment B, as well, we tried to display the data the same way for the entire region and then for Boise. As you can see, the cost per veteran has basically gone down across the board for us as a network as well. Now, part of that has to do with efficiencies and trying to become more efficient, but, clearly, we can't keep up. No matter how efficient we get, we can't keep up with the fact that more and more veterans as we get older take more and more medications. That is true across the country, and the cost of pharmacy care has gone up 15 to 19 percent. So we are losing ground in that regard. But, yes, sir, that is a general statement.

Mr. OTTER. How much of the supplemental—we heard what Boise got, $1 million of the $142 million, which I am going to have to look into that, but how much did the region get?

Mr. BURGER. We received several million dollars as part of the supplemental, and we allocated that money by bringing all of our medical center directors together and looking at how we would distribute those resources. Our start point is usually looking at the overall patients, the numbers of patients served across the system and where the greatest needs are. We actually probably two or three different times, it was about $7 million, but we two or three times went back to each of our facilities and looked at—because the money came to us so late in the fiscal year trying to spend that money became an issue, so we went back to the facilities and asked, "If we gave you more money, could you, are the providers in the community willing to take our patients and do that in a timely way?"

Mr. OTTER. And their answer was?

Mr. BURGER. In some cases, yes; in some cases, no.

Mr. OTTER. Is that because there is a fixed national cost for some of these, standard?

Mr. BURGER. There is a demand for services across our region, and it is not so easy to find a cardiologist or an orthopaedic surgeon or a urologist that has openings, that can take our patients in a timely way.

Mr. OTTER. Or will provide openings if he doesn't think that he is getting his service paid for.

Mr. BURGER. That is true, but on the fee, the way we provide that by fee, that fee is not set in any particular amount, as was referred to about——

Mr. OTTER. So that can be regionally adjusted.

Mr. BURGER. That can be regionally adjusted.

Mr. OTTER. Well, it would seem to me that if you handle, and in your testimony I picked up on 17 percent of all vets?

Mr. BURGER. That is correct.

Mr. OTTER. Is that right?

Mr. BURGER. That is correct.

Mr. OTTER. Twenty-three percent of the land mass but 17 percent of all vets.

Mr. BURGER. Right.

Mr. OTTER. It would seem to me that you should have received about $22 million—17 percent of $142 million supplement.

Mr. BURGER. That is one way of looking at it.

Mr. OTTER. Well, my concern is unless it was higher cost of delivering the service in some other area of the country, why didn't we receive our full rata share?

Mr. BURGER. I can't respond to that, Mr. Congressman. I don't know the answer to that question.

Mr. OTTER. If you could find the answer, would you provide the answer?

Mr. BURGER. I indeed will.

Mr. OTTER. Mr. Chairman, I would ask that answer that was provided be made part of the permanent record when we receive it.

Mr. SHAYS. Absolutely.

Mr. OTTER. Let me ask you a question about the prescription drugs, and we heard in the testimony from when we were trying to put a face and a voice to the person that needs the care that why can't we provide drugs, filling prescriptions, whether it is eye or visual or whatever, from a physician? If the person has a doctor's degree and fills out a prescription, it would seem to me—and if they brought that prescription, No. 1, it would certainly reduce part of the workload of that waiting list that may be the care out of private insurance paid for the issuing of the prescription and all ours would be quite simple in just filling out the prescription. Why can't we do that? Is there something stopping us from doing that?

Mr. BURGER. I will respond, and I will ask the others to respond as well. I believe that is a policy decision that needs to be made. The Veterans' Health——

Mr. OTTER. Made or changed?

Mr. BURGER. Changed.

Mr. OTTER. Oh, OK.

Mr. BURGER. The Veterans' Health Administration thinks of itself as providing comprehensive, longitudinal care to the veterans it serves, as opposed to just filling a prescription for someone.

Mr. OTTER. I would yield on that.

Mr. SHAYS. Yes. I think so we can have a candid conversation there is a part of me that believes it is a way of restricting the use of these facilities because there is the question of whether they could keep up with all the pharmaceutical demand. And there is also, I am wondering as well, not a concern that a doctor on the outside is just going to basically maybe be a little more lax in terms of deciding which type of prescription. In the VA, there are only certain prescriptions that are filled. I mean it is not all prescriptions, right, or is it all?

Mr. BURGER. If we have the medication in our formulary, yes.

Mr. SHAYS. Yes. It has to be part of the formulary.

Mr. BURGER. The formulary.

Mr. SHAYS. Yes. I mean there can be three drugs that provide the same service, and you may only provide one of them in the VA, and it sometimes raises the question to the doctor through advertising and others might decide that this other prescription is good, and then there is going to be pressure on the VA to provide that one. So I think there are other subtle things that they may not be good reasons but I think they are all—and I am suggesting that may be a factor and I am curious to have a more candid response.

Mr. BURGER. As you all know, the Department of Defense provides a pharmacy benefit to military retirees and military dependents. Using our formulary, the experiences that we have had in working with the providers in the community, I really don't believe that what you have just mentioned would be an overwhelming issue that we could not overcome.

Mr. SHAYS. OK.

Mr. BURGER. By sharing our formulary—actually, our network formulary is on our Web site, it is on the Internet. It is very easy for providers in the community to know which of those drugs we do carry so they can prescribe those specific drugs for our patients. So I don't see that as really a major issue.

Mr. SHAYS. Would the gentleman continue to yield?

Mr. OTTER. Yes.

Mr. TIPPETS. Let me make just a couple, then I know Dr. Lee wants to address this issue. Our copay is $7, which has got to be the best prescription benefit that perhaps exists in the country, including any of us that have insurance. I pay more than $7.

Mr. SHAYS. Yes. That one beats it.

Mr. TIPPETS. And I guess the other thing I would say, and Dr. Lee will talk about a couple of the issues regarding this, we can do anything that the Congress wants us to do as long as we have adequate money to do it. The average patient that walks in our medical center, the average patient probably has, the last time we calculated, $800 to $1,000 worth of drugs. That is the average patient.

Mr. SHAYS. Per?

Mr. TIPPETS. Per patient, per year. Per patient, per year. And if we were to provide this benefit, we could certainly do that, but you are talking about—I have no idea how much, but you are talking about a lot of people that want this service and you are talking about a lot of money. With that, I will pass it to Dr. Lee.

Mr. LEE. Yes. If I could respond, I think I would say that it really is not a clinical issue. I think that clinically that could be done. I think it is a policy and it is an economic issue. It is VA policy that they only provide care to those who are actively receiving care and that it be written by a VA physician.

Mr. SHAYS. And I think your point, policy/economic, I think it has to do with just the incredible potential costs.

Mr. LEE. Yes. But responding to the formulary piece, actually physicians in the private sector are very used to dealing with different formularies right now, and most health care plans have to do that. So I suspect that if we worked in combination with the private clinicians, that they would be able to adjust to our formulary.

Mr. BURGER. Yes. If I might make one other comment about that. We are very proud in our system of having a computerized patient

record that is probably the best in the Nation, probably the best in the world, the CPRS system. And over the last several years now we are getting to the point where Dr. Lee for one of his patients has an icon on his screen and he can call up where that patient has been seen anywhere in the country, and we know the records. One of the real issues about receiving care outside our system is the idea of how do I know what that provider outside did to that patient, what was that lab test that was done, what was that copy of the x-ray or of the electrocardiogram and what have you? So the recordkeeping is really a major issue for us. It is an issue in dealing with the Department of Defense in how we are trying to share patients together, because we use two different computer systems. So the recordkeeping is really important. If we more and more allow our patients care in the private sector, which makes sense for them to have care—for all of us to get care locally, how do you get that record incorporated?

Mr. OTTER. Well, reclaiming my time, I also—you know, I recognize the importance of single provider in order to make sure that we don't oversupply a patient with needs. But it would seem to me that there is, besides the costs in terms of facilities and operation that we talk about here, it seems to me that there is also a human cost, and I sometimes wonder when I hear these veterans calling into my office and I get a chance to talk to some of them, my staff talks to all of them, that there is a—it would seem to me that there is always a stress level that goes up when they know they need the drug, they know that they need the—need to be provided their pharmaceuticals within 30 days because they are going to be out, and they say, "Well, we can't get you in for 90." And it would seem to me that if there were a way that we could facilitate the private prescription, the prescription outside the system, to be filled within the system and maybe an audit or maybe a check or something like that, you folks have to tell me. You tell me where to go, and I will start calling the cadence, as far as I am concerned, because you are the ones who are going to have to tell us what is going to work in this system.

Let me go to the formulary. Now, does this mean that on the formulary there is a list of drugs that you can provide and then on that same list there may be some drugs you can't provide?

Mr. BURGER. There is a national formulary that lists all the drugs that are available across the whole system. We have within our network each of our facilities modifies that for its own special needs. Those are the drugs that are available through the formulary. If there is a medication that is needed outside, then the physician or the provider must ask—must make a request of that and actually goes to the chief of staff at each of our facilities to approve that to be purchased outside of the formulary system.

Mr. OTTER. Is the formulary that we use for the vets any different than the formulary that we use for active military?

Mr. BURGER. Yes, there is a difference.

Mr. OTTER. Why?

Mr. BURGER. Different populations, different contracts. You can get a drug better from one company than another. I believe we do very well with DOD in pharmacy and buying things together, and

I believe Mr. Tippets is correct, we probably purchase drugs less expensively than anyone else in the country.

Mr. OTTER. No question about it. And we are grateful for that, because it is needed. Mr. Tippets, let me ask you around this whole question of the availability of pharmaceuticals. The new Regional Center for Pharmaceutical Dispersement, is that going to help us?

Mr. TIPPETS. It should make the timing much better, because that is going to be up in the Seattle area. Will that help us take care of more veterans that want prescriptions? No, I don't think so.

Mr. BURGER. What we are concerned about with the consolidated mail order pharmacy is turnaround time. The quality—and it is an excellent product. I think we will give all of our veterans in the Northwest better turnaround time if we have such a facility, and we are also, as you probably know, working with DOD. There are also 1 million DOD beneficiaries in the Northwest. So if we can combine those two things geographically, that would make it far more efficient from a turnaround point of view. Right now we are using the Levenworth CMOP and I believe that our patients are fairly satisfied with that. We have had some problems, but I think we have had those turned around. The turnaround times are pretty good now.

Mr. OTTER. Dr. Lee.

Mr. LEE. Yes, I would agree. we have actually had a very active and ongoing process with full formulary adherence and using the centralized mail pharmacy system at Levenworth, which has driven, to some degree, the cost per patient that Mr. Tippets alluded to. But that having been said, I think that when we get the new regional one here up in the Northwest, it will probably improve timeliness but probably won't change much else. I think the quality and the cost will still be about the same.

Mr. OTTER. Mr. Chairman, I appreciate your endurance here with me. Let me ask just one more question, Dr. Burger, about the facilities as a whole.

[Changing microphone cords.]

Mr. OTTER. We do have utility in our Congressman from Connecticut; he can do anything. [Laughter.]

Tell me about the facilities. We have talked about the delivery of care services and the locations where they are and where they are not, but what about the state of our facilities? Are we investing in the latest care service or are we going to have to continue to go to the local hospitals, the local caregivers in order to maintain our up-to-date delivery of health care services to our veterans?

Mr. BURGER. As to the facilities themselves, we have some really aging facilities across our network, I think you know that. Actually, Mr. Tippets is our chief facility management officer, and he really helps us, as we get funds from the Congress and from VHA, to renew our facilities and do construction. He has been very much a player in that. We are really faced with a seismic problem right now in the Northwest, the whole Pacific Rim, and we have some buildings that really need seismic improvement. VHA is addressing that as money becomes available, but that is a continuing issue.

The operational dollars, the need to bring more and more veterans, I think Dr. Lee alluded to that, makes it very challenging in how one allocates the money that we have. We have this year, as

we do each year toward the end of the year, look at where we are in buying the very latest in equipment and do the best we can to provide the latest equipment. I believe that when we think in terms of colonoscopes and endoscopes and radiology equipment, by and large we are doing a good job in having state-of-the-art equipment to take care of our patients. That matches what is available in the community. But there are pockets in places. As we get into digital imaging, for example, that is very expensive to do that, and the technology changes so often that when you make a capital purchase, 3 or 4 years later you are faced with doing the same thing again. Computers, we just made a choice to purchase—to replace 25 percent of our computers. Trying to keep in that cycle has been very challenging, but I think the answer is that we are keeping up but it is a challenge. Would you add anything to that?

Mr. LEE. I think the facilities that we have in Boise, while aging, have been kept up exceptionally well, and I think they are really quite good. There really are not enough of them, and one of the things I have to face all the time is even if I got more clinical providers, I wouldn't have a space to put them. And so clinic space for more primary care is an urgent need.

And a few of the other things that exist in Boise are very capital-intensive, and that includes things like cardiac catheterization laboratories and radiation therapy. And, again, Mr. Smith, I think was very eloquent about the fact that he had to wait before he could be transferred to Seattle for cardiac catheterization. And Boise simply does not have enough size at the VA to warrant that kind of a capital investment. Those sorts of things I think we would still need to continue to partner with our community.

But I would say we heard from Mr. Smith about the difficulty of having a life-threatening illness, having to wait a bit, frankly because of nursing shortages in Seattle, to be transferred out there in a timely way, and then be out there away from his family when he is having a myocardial infarction. And similar with the radiation therapy, the necessity of transferring cancer patients who don't have long to live to a distance place away from their family and support systems in their last days. And, frankly, many of those clinicians regard it as nearly inhumane.

Mr. OTTER. Thank you, Mr. Chairman.

Mr. SHAYS. Thank you. If the gentleman has more questions after, we can come back to you. I represent probably four-fifths of a county, and in the county there are about 250,000 veterans. I represent a wealthy district and candidly many choose not to use the VA facilities, some, simply because they would just as soon go to their neighborhood hospital or the community hospital, which is—in my congressional district, we have six hospitals. But what has started to happen is they may be paying $3,000 a year for—or $2,000 or $4,000 for their pharmaceuticals, and they are saying, "My gosh, I can get the best deal in town." So they seem to feel guilty in one sense that they are not taking advantage of the program, in another sense, they say, "Well, we have the resources, we have been able to deal with it." But it is just—after a while they think they are stupid not to take advantage of this service which they are entitled to as a veteran. So what has happened is they have started to really push the VA facility. Now, I know it is being

pushed in a lot of places, but these are people in many cases who have some resources. My question to all of you is, all things being the same, if you did not provide a pharmaceutical benefit, just wasn't provided, I am not even suggesting we not, I am going to suggest the opposite, but if you didn't provide it, would there be a backlog?

Mr. BURGER. You will have to speak to Boise specifically, but as I mentioned in my testimony, 82 percent of our patients are priorities 1 through 6 already. We lead VHA in that regard.

Mr. SHAYS. But 1 through 6 has nothing to do, forgetting even the wealthy, has nothing to——

Mr. BURGER. But the priority 7s are mainly the individuals that are seeking a pharmacy benefit or are more and more populating the waiting list. What I was trying to get at was that as we now take off the 50 percent service connected and soon we will be taking those seeking care for service-connected conditions, what is going to be left on the waiting list are really priority 7 veterans, and the vast majority of priority 7 veterans are the ones that you describe are there for the pharmacy benefit. So that will become the case.

Across our system, as we have grown——

Mr. SHAYS. Let me just say, which would suggest, and then don't forget your thought, that if we dealt with it the way that Congressman Otter is suggesting, I mean if we could have all the prescription basically handled outside the VA, your backlog would disappear significantly, but then you would have to make sure your facility could handle the incredible amount of demand on the pharmaceutical.

Mr. BURGER. That is true.

Mr. OTTER. Would the gentleman yield?

Mr. SHAYS. Sure, absolutely.

Mr. OTTER. What if we just did that for a certain period of time to reduce the list and go from first time service to ongoing maintenance? In other words, what if we just did that for 6 months? What if we just took the outside prescriptions for 6 months to reduce the folks that you have got on your list?

Mr. BURGER. That would get rid of the list, but there are lots of other people that are being added to the list. That is the idea of the supplemental kind of funding. It is a one-time solution, it would get the list down, but the other reasons why people are coming in the Northwest with HMOs not being available and those kinds of things, health care in general not being available, I think the list would grow again for us, specifically.

Mr. OTTER. Yield back.

Mr. SHAYS. You wanted to respond as well, Dr. Lee.

Mr. LEE. Yes. The other issue I think is the vast majority of the medications these people are seeking are actually chronic medications. Having had that window of time and looking at them toward the end of last year, they are mostly for diabetes, hypertension and heart disease. And at the end of 6 months, those conditions will continue on, and so we wouldn't need to have a mechanism to continue to provide for those medications after the 6-month window.

Mr. OTTER. Excuse me, Dr. Lee. Perhaps I didn't make my question clear, which is not unusual for me.

Mr. SHAYS. That is simply not an accurate statement. Be careful now, he is being very subtle here.

Mr. OTTER. I am just saying that looking at the total list in its totality, and it just seems sometimes overwhelming, and the stress that goes on with those names that are on the list, and I want to go back to the human cost in terms of not only the individual themselves but the family. And I am just suggesting that if we used a time period here where we said we are going to allow those people to bring in the prescription from their own doctor and for a certain period of time until we get them into our system and can get them off the list of waiting and get them on to the list of maintenance, is that still a problem?

Mr. LEE. Oh, I couldn't agree you with more. You know, we have heard about the human costs. I just think we have to be very careful about making sure that we had capacity when the 6-months ran out to make sure that we can handle it. We are all on the same wavelength here, we want to provide that care.

Mr. BURGER. If you were to suggest a pilot, and I know Mr. Tippets once before said he would be willing to raise his hand to try that to see, but I think, Dr. Lee, really, it is what happens at the end of 6 months? I wanted to just mention that through that last month in our 5 percent increase in total numbers of veterans, about 3 percent of that was in the category A, the 1 through 6s, and about 16 percent was in the priority 7 veterans. So, again, even in our network where the vast majority of patients are priority 1 through 6, it is the priority 7 veterans that are overwhelming our system for the drug benefit.

Mr. SHAYS. And most they are interested in what is truly the best drug program in the country, if not the world.

Mr. LEE. Yes, sir; that is exactly right.

Mr. TIPPETS. Yes. A very high percentage of them are. I think if you did that, yes, you would—again, this depends on the facility, the hospital you are talking about. Yes, you would probably either greatly reduce or eliminate the waiting list but then you have to figure out what to do with those patients when they need to come into the hospital.

Mr. SHAYS. In regards to—what neither of us want to do is screw up a program that is pretty outstanding—which is outstanding, but at the same time, when you hear Colonel Jaurena speak, he is service connected and yet he is having to wait, it blows my mind. I mean it is service-related, it is not an injury that he has had as a veteran afterwards but totally connected to the service in Vietnam. And by the way, our committee has had countless hearings on the whole issue of Gulf War illnesses, and we have learned that there are many who are in fact sick because of their service, and it has been a long struggle to get the VA kind of to sort it out themselves.

Let me just ask you, as it relates—and I will get on beyond the pharmaceutical—but the pilot program, it seems to me, is a no-brainer that we should try seeing what is the impact of prescriptions being filled by outside physicians. Will they start to suggest more? Since they don't really—a VA doctor is going to focus on his patient, but he is also going to know the capabilities of the system, and so will there be more drugs per patient being prescribed versus

what a VA doctor is going to do? Who knows. Maybe not, maybe there shouldn't be, but it would be interesting to know. And it would be interesting to know how the VA then fills in actually providing this greater supply now of pharmaceuticals, because you are going to have to be able to manage more drugs in and out.

One of the things that has been a source of aggravation is that you can get a 30-day supply and you have to come in and pick them up. In some cases—I don't know, in some cases, are they allowed to be sent to the patient? They are being sent to the patient?

Mr. LEE. Yes. The Department of Defense has the 30-day supply scriptures; the VA actually has 90-day supplies of medications and mail-out refills. So we are more user-friendly in that respect.

Mr. SHAYS. So you are sending them out.

Mr. LEE. Yes.

Mr. SHAYS. OK. Well, that is interesting. Let me ask you the question of the supply of physicians, nurses, technicians, administrators. Is your biggest challenge nurses, biggest challenge doctors, biggest challenge technicians? Where is your biggest challenge?

Mr. TIPPETS. It is not administrators, by the way. [Laughter.]

Mr. BURGER. That is my biggest challenge. Let me speak from a network perspective. You know, it is interesting that we are geographically isolated in the Northwest, and that really is an issue for us. When you actually look at the number of nursing schools or even medical schools, we only have two: One in Oregon, in Portland, and one in Seattle, in Washington, in our area if you look at the number of nursing schools and pharmacy schools and so on. So there is a restriction right there, and I have already heard from nurses that nursing schools are paying faculty enough to attract faculty, so they can't expand the size of their classes and so on.

On the nurse side, it becomes very obvious, because nurses take care of patients that are in-patients, in bed. There is a dramatic shortage of nurses and that is going to continue to grow. Within VHA, the average age of our nurses is approaching 50.

Mr. SHAYS. This is all over the country. I just don't know what the—and I am told it is not just getting—well, you answer your question, I am sorry.

Mr. BURGER. And it is. It is a national issue, and it is getting worse as we all get older and need more care and so on. For us, specifically, in the Northwest, several of the medical specialties there is a dramatic shortage—medical technologists, informatic specialists, laboratory technicians. Imaging technicians are among those areas that have an absolute traumatic shortage. We have decided as a network, as VHA has decided, to start training its own. There are debt reduction programs now in people who are going to various schools. We are in the process now of trying to figure out how——

Mr. SHAYS. Is this that debt forgiveness for graduate schools?

Mr. BURGER. Yes. So we are going to try to train our own people in medical technology or in imaging or as prosthetics managers and that kind of thing. It is a national issue that I believe requires a national solution.

Mr. SHAYS. OK. I hear you.

Mr. BURGER. It is really getting to be—we are already in that crisis. I guess you hear that from your constituents.

Mr. SHAYS. Right.

Mr. BURGER. People who drive ambulances drive around our cities, can't find beds. And I am not talking about the VA, I am talking about in general. I just saw a statistic that said the average wait for one of our Nation's citizens to see their physician with an acute problem is 7 days. That is a national issue, so it is a problem.

Mr. SHAYS. Mr. Tippets.

Mr. TIPPETS. We have a pretty severe problem with nurses going back—oh, it probably started a couple years ago, and I have been the administrator of the hospital here for just about 10 years, and for the first time ever we actually had to go to the nurse registry and—you know what the nurse registry is, I am sure; yes, that is where you go to get contract nurses from a private agency to come into your hospital.

Mr. SHAYS. And your costs go up about 30 percent?

Mr. TIPPETS. Well, yes. Let me just give you an example. To get a nurse from the nurse registry costs us about $70 an hour, so we probably should have all gone to nursing school.

Mr. SHAYS. It is not too late. [Laughter.]

Mr. TIPPETS. We have increased our salaries. We have to be competitive with two major hospitals in town. We have increased our salaries, we are doing fairly well right now. In addition to that, in conjunction with the Idaho Hospital Association, we have met with the local university, Boise State, and they have agreed to increase their nurse class size by 30, and I believe that started this fall.

Mr. SHAYS. But the bottom line is nurses are a concern. How about doctors?

Mr. TIPPETS. I will let Dr. Lee address that.

Mr. LEE. Yes.

Mr. SHAYS. Dr. Lee, before you answer, if there is any—we are going to be set pretty soon to go to our open mic, and so if you would like to speak, Jason, would you raise your hand there? Jason has a mic, and what we will do is we will want you to fill out a form so we can give the transcriber your name and address and so on so we have it for the record. You won't be sworn in but you will be invited to address us. Yes, sir. I am sorry, Dr. Lee.

Mr. LEE. Just a comment on the health professions in general. I regard it as an ecosystem, and you have to have just about all the species in the ecosystem to make the whole thing function. And so we have, from time to time, seen various things, like imaging technicians become mission critical because of near shortages. As far as physicians are concerned, we are actually not too unsuccessful in recruiting most primary care physicians, but several of the specialties we need most for aging veterans, like urologists and orthopaedic surgeons, are actually earning two to three times what the maximum VA salary is in the community. And, of course, that makes it much harder to recruit them, and that means that there are backlogs in some very critical specialties that our veterans need.

Mr. BURGER. And you can't buy those services either, because the demand is there in the community as well.

Mr. SHAYS. Let me just—you talked about, Dr. Lee, listening to the face of the issue in terms of listening to what the veterans were saying, and when you heard Mr. Smith speak about the cardiac

care, what would be the challenge and what is the logic against not having him receive cardiac care in Boise? I am sure that exists here, correct?

Mr. LEE. Oh, yes. Our private medical community in Boise is absolutely wonderful. The specialists are good, well qualified, and actually we value a fairly close working relationship as far as the VA and the community——

Mr. SHAYS. So let us just talk about that particular issue, the cardiac care. Is that going to be a subjective decision? Would he have had the right to petition to get it in Boise or would he not even have the right to do that?

Mr. LEE. Well, he certainly could ask, and it is really largely an economic issue. We have talked about the fact that we have large waiting lists and we try to stretch the Federal dollars we get absolutely as far as we possibly can. And one of the ways we do that is to send cardiac specialty care to Seattle.

Mr. SHAYS. Anybody else care to——

Mr. BURGER. I would echo that. I think it is an economic issue about how much care. We could attempt to contract with a group to try to negotiate prices, but, again, the demand for the care in the community for cardiology care in the community is such that there is an unwillingness to enter in any——

Mr. SHAYS. So bottom line is you would be paying top dollar.

Mr. BURGER. We would be paying top dollar.

Mr. SHAYS. And so I am reading into your answer that if some of these fairly expensive procedures, if you contracted for the cardiac care but then added all the others that you could logically include with that, I mean different services, your budget would disappear real quick.

Mr. BURGER. Sure.

Mr. SHAYS. OK. Is there anything that you all—Congressman Otter, is there anything you want to ask before we get to the floor?

I know we are going to have to—in order to make that flight, we are going to have to——

Mr. SHAYS. Let me just say, we will stay and take the next flight if we have to, but I am just curious to know if there is anything you have to add.

Mr. OTTER. Yes. I would just like to ask Dr. Lee one question about his ecosystem, which I thought was very analogous to what our needs are. But one of the things when I take a look at the inventory of our assets, and being prior military, my prior military was in the 116th Armored Cat. I joined initially 139th engineers and then we were reorganized during the Vietnam into the 116th Armored Cat. And we had several medical units attached to us, and it wasn't unusual during our summer, our 2 months—or I should say our 2 weeks in the summer or our monthly meetings it wasn't unusual for a medical unit to come in, provide us with the necessary physicals that were required for that year and that sort of thing. But it also wasn't unusual, though I wasn't part of the medical group, I was in reconnaissance, for them not to have much to do.

And I wonder if we have even taken a look at maybe perhaps tapping that into asset for an occasional reduction or maybe a review of some of those lists. Is there any way we can take these as-

sets and work them together and maybe have a Guard medical unit come in for a weekend or something like that when they are on their weekend drill and maybe work on part of this list, because they are highly professional folks, and every one of them have a physician?

Mr. BURGER. Can I address that, actually. Well, go ahead, David.

Mr. LEE. Well, I will briefly address and then turn it to Dr. Burger. Yes, I think there is a lot of promise to that, and in fact some of that happens, and we have a number of people who do their Reserve duty, or at least part of it, by coming out to us. In fact, we have one physician from Emmit who comes to us on a regular basis, and he has helped a great deal with some of the workload and the backlog, and we do have other units that come in on the weekend. And during those weekend drills, they do provide us with substantial help, although it takes a while to orient them and get them up to speed and working with us.

Mr. BURGER. Just a technical point there. When the military restructured itself, the vast majority of the medical units are in the Reserve, not the Guard, actually, and I don't know what USAR units or other—well, Reserve units might be here but not in the Guard.

May I please respond to the question, you caught me unaware when you said 17 percent before, and it has been rattling on me. It is not 17. Seventeen percent is our market share. The $142 million was distributed by VERA by workload, and we did get our fair share. So that——

Mr. OTTER. We got a per capita.

Mr. BURGER. We got a per capita. We got like everybody else. The 17 percent relates to our market share of our million veterans.

Mr. OTTER. There is no sense in us leaving any money laying on the table.

Mr. BURGER. No. We did get our fair share of that money.

Mr. OTTER. Thank you. Thank you, Mr. Chairman.

Mr. SHAYS. Let me invite the three of you to stay, and I am going to let you have closing comments. We may have just one or two veterans, participants, here who may want to make some comments. So if you could just—so if you would identify yourself for the record. I know you have given us a sheet, but identify yourself.

Mr. HARRIS. Good morning.

Mr. SHAYS. Good morning.

Mr. HARRIS. Representative Shays and Otter, I am Eldon Harris. I am a retired Navy chief petty officer. I retired in 1958, enlisted in 1938. I have seen many changes in health care to losing lifetime health care in the Navy. I then go into civilian life and I have a company promise of lifetime health care; later, lose that. So I am almost appalled at the arguments we have or what we have to present regarding basically the pharmaceutical plan, or what we don't have as a plan, available for our veterans down at the VA hospital.

I have gone through pharmaceutical plans that you won't believe. At the present time, I am just about as good as I can get. We get our prescription filled through DOD, the wife and I both, and we also have available through Fred Meyer's, a local chain store here, we can get prescription drugs filled here for $3 a prescription, and

that is for your regular prescriptions if they are generic and $9 for the others. So to me, we are missing an awful lot someplace. I think we need to go back clear up to where this ball starts to roll and go to these pharmaceutical companies.

Another appalling thing is that if you go to our borders in Mexico and Canada, 40 percent, or maybe more, of the people going across the border to fill their prescriptions are either retired farmers or retired military that don't have a medical plan or they are not qualifying for it. This is sickening. If these pharmaceutical companies can go to Mexico or go to Canada, sell the plant and sell these drugs for that price outside of losing their lobbying policies here in the United States, there is no reason they can't do it here. We have got to be as good a country for the companies as anybody is.

Mr. SHAYS. Let me say we had a hearing in Boston on the whole issue of the pharmaceutical program, and if you leave your address with us, we will send you the—should we send the transcript—yes, we can send you the transcript of that and be interested in your comment. One of the challenges that exists for pharmaceutical companies, you know that they are basically price controls in both. I wager to say there has been no major medical breakthrough of any pharmaceutical company in Mexico because of it. And I would say to you there is one company in California that has invested $1 billion in hoping to retard the deterioration into Alzheimer's. They thought they were going to have a major breakthrough, had a lot of investors in, but right now it has not proved successful. That $1 billion is out the window. So we are trying to find the way you get the pharmaceuticals to create the new drugs and invest and risk and so on, get a return far more than what it costs to produce but for all they are investing.

What we did do was we did vote in the House for legislation to say that if you could get a drug cheaper in Mexico or Canada, as long as it was FDA-approved, that you could import it in as a way to see if we could kind of level pricing in the United States. It is very controversial. Your program that you get, though, you are not getting from the VA, you are getting through the Department of Defense.

Mr. HARRIS. This is true, what they call the TriCare type thing.

Mr. SHAYS. And your testimony is that you are content with that program.

Mr. HARRIS. Yes. This is a fantastic deal.

Mr. SHAYS. Yes.

Mr. HARRIS. But here, again, you have to be over 65.

Mr. SHAYS. Right.

Mr. HARRIS. One other thing on this, I noticed in the conversation there is a difference between minimum copay through the VA and what I can get it at Fred Meyer's. Evidently, Fred Meyer's is getting paid for the difference through Medicare, but the DOD or VA should be getting——

Mr. SHAYS. What the VA, I don't know if DOD does as well, is we buy in bulk, and we are able to basically pass on that savings to the veteran.

Mr. HARRIS. Well, this rings in another problem, just to touch on it in a minute. My wife has a condition that takes a special pill. When we first moved here 3 years ago from Washington State we

went to Mountain Home Pharmacy, and it got to the point where she could not get her prescription filled there, because they had no generic, no crossover. And then we come to find out that the small pharmacies they only order enough of this one pill for prescriptions for their local people on the base. So here again you have a cost breakdown. I did forget when I introduced myself, I am the president of the Fleet Reserve Association Branch 382. I have been a member for 49 years, so I have seen a lot of changes and have followed this man the last 3 years too. The man sitting behind me and I have run across a few years, so I am watching all of you. I haven't got many years to go but I am watching. I thank you for this opportunity.

Mr. SHAYS. Thank you. It is an honor to have you testify before the committee. Thank you very much. Mr. Smith, I think you also wanted to make a comment.

Mr. SMITH. I am Tom Smith, of course. The comment I had to make was that the medical flights to Seattle. On the Cardiac Unit, if you are in there on an emergency, they do fly you up. They fly you up with a medical plane, a nurse's assistant and the pilot. And the plane, I am sure that costs a bunch, and when we start figuring things out, the copay with my insurance would have been far cheaper than to have the medical procedure done in Seattle. So I don't understand why that there is a regulation here that stops the VA from paying a copay with my private insurance when my private insurance took care of everything but. And it is just a fine line here, and I don't understand what it is and why it should be there.

Mr. SHAYS. You know, I should know the answer to the question. I understand why it exists in Medicare because it is the same thing: It is the government paying the government. So whether the government is VA or the government is Medicare, to get a copayment from Medicare is just taking one part of the government to the other, but I don't know the private side and why we are not able to do it on the private side. Can you speak to that at all? Mr. Smith, you should sit down, I am sorry, because the transcriber has the mic.

Now we have one other person who is going to—OK. And we will go to the next person afterwards.

Mr. LEE. Yes. I am very well-versed on that one. The copayment of the private insurance is a matter of VA regulation, and I am told I can be disciplined if I ignore VA regulations.

Mr. SHAYS. No, I understand you have got to follow regulations. Usually when something seems absolutely absurd there is a reason, and you may not agree with it, yes, but there is a reason why, and I wish I had why we don't do it because it seems like a no-brainer.

Mr. LEE. Yes. I don't understand the rationale either. I agree with Mr. Smith. By the way, the cost of the air ambulance is about $4,000.

Mr. SMITH. The copay on that would have been less.

Mr. SHAYS. Right. But how much is an operation in a hospital, what would that have been in a private hospital?

Mr. LEE. You are looking right around $45,000.

Mr. SHAYS. Right, 45. And at the facility, how much at your facility?

Mr. BURGER. Probably well under $25,000.

Mr. SHAYS. Right. So you are getting your—you are looking at total costs. But in the end, we have got to decide there is a point that even costs notwithstanding there should be a critical mass of service provided for a veteran, and I don't think anyone here is denying that. We put these administrators in a difficult circumstance. We give them a certain amount of money, we have a lot more veterans each year, and we could yell at them, but it really rests on Congressman Otter's and my shoulder to just keeping running out more benefits for—more money for the hospitals, which we do every year, but it is never quite enough.

Mr. SMITH. I agree that there is not much money to go around, that is No. 1. And the only thing that I can't understand and still don't understand is why that they wouldn't be able to have a copay that would pay with my insurance if——

Mr. SHAYS. I don't have the answer to your private—why the private insurance, and you have—I am going to leave this as a requirement of my committee staff. You are looking at the Director, Larry Halloran. Larry will make sure you get an answer and Butch and I get an answer as to why there is not the private copay and then if there is anyone in the audience who could answer, I would love it. But I should know it, I think I was told and I think I have forgotten. But it may make sense or may not, and we will look into it, and this is one of the values of the hearing. So you have made a number of contributions today, and I thank you.

I think we will get to our last witness, not our witness but our last person invited to make comments. And you have given a form to—OK, yes.

Mr. WILLIAMS. My name is Gordon Williams, and I am combat-wounded Marine, and I am 6-year paratrooper, 22 years active service. And unlike the rest of the people that testified, I, like a commander, see the people in action at the VA hospital because my wife and I volunteer there 2 or 3 days a week. We work there to supplement the people that get paid. I can tell you that this is one of the best hospitals that I have ever been in. I have been in a few. They have the best medical staff and they are overworked and in most cases underpaid. Mr. Tippets runs a tight ship. There are no wall-leaners, there are no clipboard carriers, they work. Anytime you—and they always go the extra mile. If you need a question answered by a doctor and you are in there, he will take the time to do it, although many people sit out there. And I guess I am beating a drum for this hospital, and I damn sure am.

Mr. SHAYS. Well, you know what? I was going to ask if any of the gentleman want to have a closing comment, but I think you would be foolish to respond. [Laughter.]

And we are going to let your comment be the last word, how about that?

Mr. WILLIAMS. How about that.

Mr. SHAYS. OK.

Mr. WILLIAMS. Semper fi.

Mr. SHAYS. Thank you very much. We will close this hearing. Thank you very much. Oh, excuse me, before we close, I want you to sit down. I do want to thank very much the people who worked hard on arranging this hearing. Cheryl Miller, Business Manager of VWF Post 63, thank you very much, Cheryl. We thank Jim

Adams, Congressman Otter's district staff, from his staff, and Mark Warbiss, Communications Director as well from the staff of Congressman Otter. And also Gayle Ruts, Northwest Transcripts Court Reporter. Thank you Gayle. Is there anyone else we should thank?

Well, I just want to thank all of you for participating. It has been a wonderful hearing, very educational. I am delighted that the committee came out. I just apologize to Butch that we didn't come out sooner, but we will back on other issues as well. And thank you all very much. Butch, do you have anything?

Mr. OTTER. No. I thank everybody for being here. I really want to thank Congressman Shays, Chairman Shays and the entire staff, Larry, everybody, for coming out, because I know how important, and I think you too, know how important it is to these folks that were here in this room here today, and I thank you very much, Mr. Chairman.

Mr. SHAYS. Thank you very much. This hearing is adjourned. This first adjourn didn't happen.

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

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