THE AMERICAN LEGION
DEPARTMENT OF NEW YORK

ANNUAL MEDICAL FACILITIES HEALTHCARE REPORT 2014 2015

Stratton VA Medical Center

James Peters VA Medical Center

Canandaigua VA Medical Center

Hudson Valley Healthcare System –
Castle Point Campus
Montrose Campus

Frank J. Peters
Department Commander 2014-15

James W. Casey
Department Adjutant

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The American Legion, Department of New York
Annual VA Medical Facilities Healthcare Report

EXECUTIVE REPORT

VA Medical Facilities Healthcare Report 2015
By R. Michael Suter, Chairman
Department Veterans Affairs & Rehabilitation Committee

BACKGROUND

The Veterans Health Administration (VHA) is the provider of choice for over eight and a half million Veterans. In addition to leading the healthcare industry in areas such as specialized services, primary care, and research; VHA clearly provides the most cost effective healthcare of both private and public entities. This healthcare system was created to address the unique healthcare needs of Veterans.

In 2003, The American Legion created the System Worth Saving (SWS) to conduct site visits to VA medical facilities to determine how the VHA provides for the medical needs of generations of veterans through its Veterans Integrated System Networks (VISN) managed structure. The purpose of the program was to assess the quality and timeliness of VA healthcare and to provide feedback from veterans on their level of care. Each year, the SWS Task Force selects a different healthcare focus topic. The findings and recommendations are compiled into a publication which is presented to the President of the United States, members of Congress, senior VA officials, and fellow Legionnaires.

During the 2014 Department Convention, resolution 6 was passed creating a Department VA Medical Facilities Healthcare Report and Task Force to conduct site visits to determine the quality and timeliness of care provided to the veterans of New York State. The VHA has two VISNs in New York State. VISN 2 has six medical centers and 29 community outpatient clinics. VISN 3 has 7 medical centers and 22 community outpatient clinics. Additionally there are 16 Vet Centers within the state's borders.

Immediately following the Department Convention, R. Michael Suter was appointed Chairman of the VA Medical Facilities Healthcare Task Force, Steve W. Bowman was appointed Vice Chairman for VISN 2, and Daniel A. Morea Vice Chairman for VISN 3. The Chairman and Vice Chairmen selected the visitation sites for the American Legion year and the Chairman made initial contact with each facility to request a visitation and select visitation dates. A Task Force Member training school was required prior to starting our visitation program and Patrick R. Rourk was appointed the Task Force

Trainer. A school was conducted in Albany, New York during October 2014 with 14 Task Force Members present.

Prior to the visits, each facility responded to a questionnaire created to measure specific areas of interest in the delivery of medical and long term care, physical plant, and gender specific issues. The visits examined the overall challenges, fiscal operation, enrollment, accessibility and continuum of care, staffing and affiliations, community based clinics, long term care, mental health, specialty care, healthcare for women veterans, outreach, physical plant, and VA Voluntary Services.

KEY FINDINGS

The new pay tables approved by Central Office have caused concern for leadership when hiring new staff. It appears that no consideration or guidance has been provided concerning current staff and the new pay tables causing potential pay inequities between current staff and new hires. The hiring process has been slowed even further as all employee classifications for new hires are now conducted by the VA Central Office (VACO) in Washington, DC. This policy change may slow hiring for needed staff and could have direct impact on access to healthcare. Medical Center budgets continue to lag behind by two years and unfunded mandatory pay raises continue to have a negative impact on staffing issues.

GSA is now directly involved in Medical Center contracting processes. Lengthy process delays and the inability of Medical Center Directors to be involved with local venders could, and in some cases, are placing contracts in jeopardy of being canceled. This policy may have a direct impact on timeliness and quality of healthcare for veterans.

The projected Maintenance & Repair budget has been reduced by 33% by Central Office and the funds have been rerouted to personnel issues at Central Office. As an example, the ventilation system in a VAMC operating room was determined to be inadequate and delayed funding limited the use of the OR until proper ventilation could be installed. Deferring maintenance projects can only lead to larger and more expensive projects in the future.

Veterans continue to be on Wait Lists for longer than 30 days for some specialty care. In some cases Veterans are waiting well beyond 60 days for certain specialty care. The main reason generally evolves around either a shortage of doctors, both within the VA and the community or the location is rural/remote and placement becomes difficult.

When asked about the Veterans Choice Card, managers were somewhat unsure just how it would impact veterans within their catchment area or their current fiscal budgets. Many managers understood that the Choice Card was for primary care only. To further

complicate this new program, a contract was entered into with Health-Net to provide community doctors for the Choice Program. This process has been slow to start and is confusing to both VA medical staff and veterans. Very few community doctors are signing up to provide health care through the Choice Card Program. It appears the Choice Program was not funded completely causing the VAMCs to use fee based dollars to fund the Choice Program causing funding shortages for that program.

The VA also faces a budget shortfall of nearly $3 billion. The VISNs have been informally directed to reduce all travel to emergency only, consider furloughs, hiring freezes and other significant moves to reduce the gap. The VISN 2 Director estimated that $9 million would be returned to VACO for redistribution for healthcare need. The Director indicated that some dollars would be returned to the VISN for healthcare. The VISN 3 Director indicated about $13 million was being returned to VACO. The current thought is that most returned funds would come back to the VISNs. VA officials are expected to petition Congress in late July or early August to allow them to shift money into programs running short of cash.

In the last year, the VA has increased capacity by more than 7 million patient visits per year, doubling what officials originally thought they needed to fix shortcomings. Department officials did not anticipate just how much physician workloads and demand from veterans would continue to soar. At some major veteran's hospitals, demand was up by 20 percent. Doctors and nurses have handled 2.7 million more appointments than in any previous year, while authorizing 900,000 additional patients to see outside physicians according to VA records.
Both VISNs reported extensive escalation of treatment of Hepatitis-C using more effective, but also more costly dollars not budgeted for this treatment. The situation is the same on both local and national levels: budget shortfalls for new pay scales; more centralized control over employee classifications, contracting and supplies; maintenance needs for old buildings; cost overruns on existing contracts, and the list goes on. Annual budgeting is based on two year old veteran enrollment numbers while the local medical centers are directed to do outreach and bring more veterans into the healthcare system. Senior employees (SES) continue to advance after failing at their current jobs, a very high percentage of true leaders in the system are currently eligible for retirement. When this happens, the VHA appoints interim directors at most levels while they try to find a qualified employee to fill the position on a permanent basis.

Conclusion of the Executive Report Summary

Congress needs to provide the oversight as they have directed themselves to do. Waiting until something goes wrong to investigate is too late. Congress needs to provide a budget process that uses real numbers, not old data. They should also treat everyone equally for benefits. There was no means testing at entry to active duty and combat is combat regardless of your current household income.

VHA and the VA need to construct workable and understandable programs prior to initiating them including ensuring or training employees about programs. VHA and VA need to be able to hold all employees accountable for their actions or lack thereof on a timely basis without sending them home to do nothing except draw their pay. VHA and VA need to be more involved in the training process for future leaders.

We as an organization need to be much more aware of what is happening at our medical centers and to our healthcare. The American Legion, Department of New York has taken our first step in this endeavor and will continue to focus on a united team spirit with the VA, VBA, and VHA. Locally, we can see and voice the needs of our veterans only if we, as veterans, are willing to open our eyes and act. Our program can conduct Town Hall meetings throughout the state; however, if nobody attends, we accomplish nothing. Just because you might not be eligible for healthcare should not be a deterrent from your participation to ensure those veterans who are eligible receive timely and effective healthcare.

Samuel S. Stratton VA Medical Center Albany, New York

Date: November 18-19, 2014
Task Force Members: Steven Bowman
Denise DiResta
Charles Burkes

Overview

The goal of the Task Force was centered on the access to timely and effective healthcare for both female and male veterans. This centered focus gave us insight into many aspects of the operations of the Stratton VA Medical Center ranging from budgetary to contracting to personnel and renovations.

The Task Force met with the Execute Staff and discussed matters related to budget, personnel, and construction ongoing at the VAMC. The Executive Staff consisted of the Medical Center Director, Linda Weiss; Associate Director, Scott Guermonprez; Chief of Staff, Dr. Lourdes Irizarry; and Associate Director of Patient/Nursing Services, Deborah Spath MSN RN.

The overall Medical Center budget from FY2013 to FY2014 showed modest increases which are primarily tied to staffing issues. The proposed budget for FY2015 includes an increase as expected based on the increased need for staff. The Medical Center continues to have specialty care staffing needs in orthopedics, radiation & oncology, and dermatology.

The following budgetary and personnel issues were a concern:

- The new pay tables approved by Central Office have caused great concern for leadership when hiring new staff. There is no consideration given current staff which results in the new policy causing pay inequities between current staff and new hires. This may have a negative impact by causing morale issues among employees.
- Employee classifications, now conducted by Central Office, have slowed the employee hiring process tremendously.
- The Medical Center budget continues to lag by two years and the unfunded mandatory pay raises continue to have a negative impact on staffing issues.
- GSA is now a player in the Medical Center contracting process. Due to the lengthy process, the contacts for the CBOCs are in jeopardy.
- All Medical Center information technology processes are managed by Central Office. This policy has eliminated all flexibility at the medical center as patient concerns increase and IT needs increase. There have been several occasions where supervisory staff and the medical center director where without computer access for extended periods of time.
- The projected Maintenance & Repair budget has been reduced 33% by Central Office and the funds have been rerouted to personnel issues at Central Office. A case in point is the ventilation system in the OR which was determined to be inadequate, therefore limiting the use of the OR until a proper ventilation system can be installed.
- Contracting processes are now managed by the VISN Leadership (previously managed by the Medical Center Director) which limits flexibility and cost effective changes as needed. However, due to the strength of leadership, communications with VISN leadership has been ongoing on a weekly basis and has yielded great success in accomplishing the contract goals.
- The electronic Wait List currently has 59 Male and 3 Female Veterans listed and the medical staff is working daily to reduce the numbers on this list.
- When asked about the Veterans Choice Card, management was somewhat unsure how it would impact veterans within the catchment area. They were lead to believe that it pertains only to primary care and not specialty care. Additional information and clarification are needed.

Veterans Homelessness

The homeless Veterans Program is managed by Kirsten Danforth who can leverage the assistance from any provider as needed. She manages the outreach workers and HUD/VASH programs for the entire catchment area which includes 264 in use Vouchers. Her ability to move assets around the catchment area as needed is exceptional.

Suicide Prevention

The Suicide Prevention Program managed by Joe Hunter, PHD, tracks approximately 58 Veterans (2013) who have been determined to be at high risk for suicide. The efforts of Joe Hunter and the ten psychiatrists, with limited social workers have paid off. Their attention to detail and patient advocacy has been outstanding to insure these veterans do not follow through with their attempts. Since October 1, 2014, fourteen veterans have attempted suicide with only one actually following through.

Tracking of suicides by geographical areas within the catchment shows the following percentages of High Risk veterans and their location:

Capital District	**48%**
South	**7%**
West	**10%**
North	**35%**

Currently all Suicide Prevention resources are located at the Medical Center (Capital District). Resources within this program should continue be focused to the areas with greatest need (Capital District & North).

Enrollment (Business Office)

The Medical Center Business Office is contained within the Veterans Service Center and managed by James Arrington. This office is responsible for enrollment services, eligibility, insurance billing, Tricare, and Information Management. Over the past two years, the entire staff has turned over due to retirements and personnel changes. The new staff (primarily veterans) is compassionate and willing to go the extra mile to ensure all patient concerns are addressed.

Patient Advocate

The Patient advocate is also housed within the Veterans Service Center and is staffed by Bridgette Quill who is a very caring person. She has developed a process wherein when a patient calls with a concern about their care, they are forwarded to the Primary Care Team RN to address their concern directly. However, when the RN cannot be reached or the veteran's issues are more complex, the Patient Advocate must bear the brunt of the patient's concerns. With 266,942 unique patient appointments within FY14, there happens to be a large volume of calls being made to the patient advocate. In-as-much-as there is only one person handling all calls, this appears to be a serious work overload issue.

Military Sexual Trauma

Doctor Amanda Kras manages the Military Sexual Trauma (MST) program and participates in treatment of both male and female veterans. Her use of "in-place"

resources is exceptional in a time of reduced budgets. The Mental Health, PTSD and MST providers overlap and, looking towards the future, the loss of a provider or two would severely hamper patient centered care.

OEF/OIF/OND

The OEF/OIF/OND program will soon change to Transition Care Management (TCM) and is overseen by Leah MacDonald, Social Worker. She currently manages 700 Active outreach cases to include all information updates in the computerized patient records as well as working with inpatient cases herself. Her greatest concern is the retention of their current system and linking veterans with Community Services where they live. With over 90% of all her referrals being for Benefits Counseling her communication with County Veterans Service Agencies is a must.

Women Veterans Program (Center)

The Women Veterans Center is managed by Jane Weber who serves as both the program manager and administrative clerk. MS. Weber works with Doctor Grimm (Red Team) and (Women Health Committee) to ensure all OEF/OIF/OND women are provide primary care. The Women Veterans Center is located on the eighth floor of the medical center consuming one entire wing. However, the doors leading to the Women Veterans Center are not secure thereby allowing access by male veterans.

The center provides extended care for all women veterans and is open five days a week with extended hours available for those who work on shifts. The medical treatment provided to women during and after birth is exceptional. The mammography program provides training and information for every women veteran seen.

Throughout our visit to the Women Veterans Center, the privacy of the patient came first. The design of the individual treatment rooms ensures privacy at all times and information packets and helpful hints are available throughout the care process. Additionally, a Women Veterans Social Group is in place and provides a great environment for friendship and peer support.

Pharmacy

During our visit with the Pharmacy staff, we were introduced to “Tug,” a Medication Transport Robot, which is used primarily during off hours to deliver medications from the pharmacy to any floor within the Medical Center. During the month of October 2014, 150 personnel hours were saved by using this robot system. Efforts are currently under review to evaluate the increased use of the Medication Transport Robots. This VA Medical Center currently has two robots.

Stratton VA Medical Center CBOC Site Visits
Dates: December 11-12, 2014

Task Force Members: Steven Bowman
Kevin LeBeouf

Plattsburgh CBOC

The Plattsburgh CBOC is a Contract Model facility that has an operating budget of $1,036,273.00 and had 4,586 actual patient appointment in FY14. The clinic is staffed with the following personnel:

1 – Doctor, 1 – Nurse Practitioner, 3 – Registered Nurses; one of which is the Facility Administrator, 2 – LPNs, 2 – Health Technicians, and 2 – MSAs (clerks). There Behavioral Health Clinic includes 2 MSWs.

The use of the tele-medicine and tele-health systems seems to be growing. Many of the veterans who use these services like them versus the lengthy drive to the Stratton VA Medical Center.

The Home Based Primary Care (Tailored Care) is managed from this site for the entire North Country (which includes Clinton, Franklin & Essex Counties). This program allows the veterans to receive appropriate care while they stay at home and only need travel to the CBOC when absolutely essential to ensure adequate care is given.

The Tele-Retinal program is widely used and continues to grow. This innovative service allows for veterans (both male and female) to receive the evaluations they need on a timely basis.

The Plattsburgh CBOC is a growing clinic. There is flexibility in the current facility for further growth as needed. The staff is welcoming and able to assist veterans with almost any concerns they may have.

Malone CBOC

The Malone CBOC is a Contract Model facility that has an operating budget of $917,171.00 and had 1493 actual patient appointments in FY14. The clinic is staffed with the following personnel:

1 – Doctor, 1 – Registered Nurse (who acts as site manager) and 2 – MSAs (clerks).

The FY15 projected budget for this site is $1,277,944.00, a $360,773.00 increase for this contract when the actual number of veterans enrolled is declining.

When we arrived at the CBOC, the parking lot was not cleared of all the snow from an earlier storm, making access to the facility difficult, especially for elderly & disabled veterans. The parking area for the staff had not been plowed, forcing the staff to trudge through deep snow to access the facility.

The facility is small, dark, and totally unappealing. The staff has done what they can to make it attractive to the patients, however, the hallway leading from the waiting area (which seats maximum of five people) to the treatment rooms is narrow and dark.

It was questionable as to whether a wheel chair could turn around in this narrow space, however, a test was conducted and we found that a wheelchair can turn around (with some difficulty). The treatment rooms are small and provide only minimal privacy. There are no rooms set aside specifically for female veterans, therefore privacy cannot be provided for them. Requests by the contractor to the landlord to change the lighting or at least clean the light fixtures, have elicited no response. The tile floors are dingy and are not cleaned, stripped, and waxed regularly. Inspection by VAMC senior leadership has resulted in communication/correspondence to the contractor to address these issues on an expedited basis.

Continuity of physicians is lacking with turnover as frequently as 2 months. There is insufficient space for new/additional services such as telemedicine, telehealth, and PACT; none of which can be implemented as the contractor requires a substantial increase in compensation for any change in service level. Secretary Shinseki signed for closure of the CBOC on May 5, 2014.

Saranac CBOC

This facility is a Staff Model Facility that has an operating budget of $77,038.00 for FY14 and a projected budget of $79,952.00 for FY15. This facility is staffed with 1 – Doctor, 2-RNs, 2- LPNs, 1- Health Technician and 1-MSA (clerk).

This facility is brand new and has been located in an area that is easily accessible for all veterans. The design of this facility provides for specific areas for tele-health visits, tele-retinal exams, and secure areas for female veterans. This facility was designed

with privacy for the patient in mind and is well laid out. There is adequate flexibility within this facility for future expansion as needed.

The specialty clinics provided at this facility via Tele-Health include the following: Anesthesia, CRCS, Diabetes, Endocrine, Gastro, Genomics, Gem Memory, Hem/Oncology, Hepatitis C, Neurology, Nutrition, Orthopedics, Palliative Care, Polytrauma, Prosthetics, Renal, Rheumatology, Sleep, and Speech. This facility truly is a full service Clinic.

The staff is warm and very helpful making it pleasant for the patients.

Glens Falls CBOC

Glens Falls CBOC is a Contract Model facility with an operating budget of $1,546,000.00 for FY14 and projected budget of $1,546,000.00 for FY15.
During FY14, the facility provided healthcare to 353 female and 5607 male patients.

This facility is located in the center of Glens Falls easily accessible from the interstate and surrounding main highways. The clinic is located on the second floor of a facility that is the home of a pediatrics clinic. Parking is ample and well established. Access to the facility is through a large handicap accessible door with immediate access to an elevator to the CBOC. This CBOC covers the entire 2nd floor and has room for growth. They are provided great support from the landlord.

The design of the clinic provides for a large waiting area, clean and well lit hallways which provide ample room for wheelchairs. The Blood Drawing area is separate from the rest of the clinic so as to provide privacy for those patients being seen by their providers. The provider rooms are spacious and well lit with innovative means to ensure privacy. The female care areas are completely separated from the areas frequented by male veterans.

There is enough staff at this facility to handle the current patient load and possible a slight increase without too much difficulty.

Town Hall Meetings

Prior to the Facilities Site Visits, Town Hall Meetings were held at the following locations:

Saratoga, NY - American Legion Post 70
Hudson NY – American Legion Post 184
Plattsburgh, NY American Legion Post 20

Albany, NY American Legion Post 1520

Although attendance was low, these meetings provided no issues of concern and gave the impression that the healthcare system throughout the Stratton VAMC Catchment area was favorable.

Recommendations

It is recommended that:

- management review the current work practices and look at adding a second staff person to assist with the Patient Advocate duties at the Medical Center.

- additional resources be physically placed in the North Country to address the increased high risk veteran population.

- management consider additional administrative assistance for the Transition Care Management program given the work load volume.

- some type of security system be installed in the Women's Clinic to promote safety and privacy for women veterans who use the center.

James Peters VA Medical Center Bronx, New York

Date: November 18-19, 2014
Task Force Members: Daniel A. Morea
Robert Feliciano
Vito Pinto
Luis Navarro

Leadership

The visitation lasted for two days, beginning with an executive meeting with the Medical Center Director, Dr. Langhoff; Associate Director, Vincent Immiti; Chief Nurse Executive, Dr. Capitulo; Quality Manger, Carmen Lopez; and Public Relations Officer, Jim Connell. Each member of the Executive Team had a copy of the written report responded to by the Department of New York American Legion. Dr. Langhoff spoke of the relationship with Mount Sinai Hospital, the Hospital for Surgery, and Columbia Medical Center. These facilities are available contractually, when services are not available at the Medical Center. The focus on homeless veterans and the Medical Center's response to same through enhanced medical care, housing, and other services on an individual basis. Dr. Langhoff also spoke about the hospital's relationship with Montefiore hospital for female veterans for special services, not currently provided at the Medical Center.

The team asked questions regarding the latest IG report, and Carmen Lopez informed the team that each of the recommendations had been accomplished. She further inform us that some of the IG findings were due to administrative errors, stating that the recording did not notate members who were actually present at either peer review meetings, or special meetings, as notated in the IG report. The Associate Director stated that he looked forward to any suggestions that the organization may have, and that through dialogue we can continue to enhance the quality of care to all veterans.

Women Veterans

The team met with the Women's Program Manager, Angela Crafton-Murray L.C.S.W.; Carmen Barrios; Clinical Nurse Manager for women's program, Beverly Briggs RN; and Dr. Katie Capitulo. This team appeared to have empathy and is sincere in their desire to provide needed services to women veterans. A major concern is lack of child care for mothers who visit the facility, as the hospital does not provide child care. However, staff assists, on their own, watching small children while the mother is being examined. There is a coloring table and a few toys in the facility. A new wing for female veterans is currently under construction. The most prevalent item on the team's wish list is the establishment of child care services for patients. It was their opinion that this would

enhance enrollment at their facility. Safety and security are paramount concerns in treatment for female veterans.

This unit coordinates with the OIF/OEF/OND team. Due to the sensitivity of the issue MST during service is addressed at various periods of healthcare.
The hospital is scheduled to receive its initial Mammogram machine during 2015. There are two female doctors and one male doctor for this team. If a female veteran has a concern she has the woman's coordinator and the clinical health manager as resources, as well as the patient advocate. OB/GYN Maternity care to include prenatal, delivery and newborn care, fertility and radiotherapy/radiation therapy are fee based out. Dr. Bain has recently joined the team of experts in women's healthcare, and she has been a valuable asset in training staff throughout the hospital in the best practices. The hospital has a Women's Healthcare Committee that meets on a regular basis. The gender specific services delivered are at the Bronx VAMC: pelvic exam and cervical cancer screening as well as Osteoporosis treatment. Obstetrics are referred and menopause management is currently performed by outside sources. The most prominent barrier for female veterans is their lack of knowledge regarding the excellent services offered by the hospital. The staff would also like to see an increase in family therapy, as well as access to dental care.

Enrollment

Jan Bowers is the program manager and Jeanette Zayas is her assistant. Walk-ins are the most effective measure of enrollment. However, the Van and community based outreach provide knowledge of the services offered, this, along with the Affordable Health Care Act have lead a number of veterans to seek enrollment into VA healthcare, thereby allowing a veteran to avoid having to purchase healthcare if accepted in the enrollment process. Post Deployment events have a success rate of 75% enrollment for today's Guard and Reserve units. Community awareness events are what this office would like to see enhanced.

After the initial enrollment, veterans will no longer have to provide income information, as VITA will access this information from IRS reports.

Patient Advocate

The patient advocate, Jean McLaughlin, reports directly to the Director's office at this facility. The hospital has a software program for each complaint brought to the advocate. This program allows the advocate to write the complaint and follow up with results. Protocols are in place and Jean is accessible to any veteran who wishes to come to her office on the ninth floor. It is located directly across from the executive offices. Jean pointed out that the hospital now offers some evening hours (Wednesdays) and Saturday for the veteran who works.

Business Office

Sheri Moore is the Program Manager. The facility has an attractive and well equipped mobile van which attends college campuses, community events, and yellow ribbon events. At many of these events program staff also attends. Enrollment materials and some specialized equipment for testing have been added to the Van. Some of our more senior veterans have incomes or net worth which previously made them ineligible for health care. For those veterans who need fee based care, the contractor has forty-eight hours to contact the veteran and must schedule an appointment for the veteran within five days within a thirty day period. A letter is sent to the veteran with this procedure and a telephone call is made as a follow up to the veteran to ensure timeliness.

The staff recently was assigned a new positon to work within the compensation examinations. The hospital is receiving a grant for a new van which will have room for four wheelchairs and four seats. This van will be able to accommodate various sized wheelchairs.

Mental Health

This meeting included representatives from the homeless and suicide prevention programs, the program management officer, chief of psychology, chief of psychiatry, patent care center director, clinic coordinator of outpatient psychiatry, MST coordinator, and the Community support services manager. As noted above, MST interviews are not only done during the initial interviews, but during follow-up visits as well, in-as-much-as MST carries both a stigma and sense of shame for some veterans. Some of the therapists pointed out that MST is very similar to a diagnosis of PTSD, thus training for initial contact and primary care staff has taken place to provide a safe and secure environment for these patients.

Training in CBT, CPT, pain management, anger management, robust consults, as well as primary care are part of the best practices. Although the team asked about our most recently returning veterans, many of the staff indicated that all eras of veterans have mental health issues which need to be addressed. The entire team seemed to be empathetic, caring, and do not want to focus unreasonably on one specific era of veterans. When asked about the estimated number of veterans returning from the Middle East at one time, due to probable military downsizing and the end to current conflicts, the team felt the staff was adequate to handle both current and new veterans. The hospital has two CBOCS both of which have mental health specialists along with medical care for treatment purposes. Specialty care is done primarily at the James Peters VAMC, with the exception of outpatient mental health therapy and psychiatry. The written response to Department of NY American Legion provides the various therapies and number of veterans served. The safety and security of our veterans as well as maintaining their dignity were primary concerns of those in attendance. The main concern for our female veterans was the issue of a single point of entry, which was also discussed at the exit interview. Cost and space were overwhelming challenges in making this a reality. Treatment locations are separate for male and female veterans. Buddy Systems for our returning veterans and for those who feel lost from society would be a tremendous help, and the staff looks to organizations such as the American Legion for any assistance they can provide to establish this type of program. Dr. Golier spoke about the need for physical exercise and dental care, as two areas that are of immense importance to veterans undergoing mental health treatment. Many patients who suffer from MST and PTSD, as well as other mental health disorders, need proper nutrition and need properly maintained teeth in order to sustain their health and improve their emotional states.

Community Support Services also serves as the homeless coordinator and attends many of the community events in an attempt to reach our veterans. When asked about HUD VASH vouchers, she stated that most of the vouchers go to the Bronx County, as Westchester has only limited access under HUD. However, the VAMC continues to meet with Westchester communities who seek housing under the HUD VASH

guidelines. In 2014, the facility placed 126 females and 110 males. We spoke about reissuance of previously approved vouchers. This issue is handled on a case by case basis. Most of our homeless female veterans have children. There are approximately 1,300 homeless veterans in the Medical Center catchment area, 130, or 10%, are estimated to be female. After a voucher is assigned, a case manager works with the veteran to ensure HUD VASH compliance and success in their placement. There is a Housing PACK team to provide holistic service to the veteran. Public Housing requires 30% of the veteran's income be available for housing costs.

We also discussed veterans' suicide, whose numbers are low in the Northeast. According to national statistics, this issue is much more prevalent in the South. The team does have constant contact with the suicide hotline out of Canandaigua although the national hotline provides daily reports for potential risks. The hospital has worked with the VA Central office providing various stickers, magnets, and articles for veterans who might be at risk, as well as training the VHA staff in signs of suicide. The team has also reached out to veterans' organizations and other community organizations for assistance to be vigilant for such signs among their veteran populations and provided them with the hotline telephone number to assist veterans with suicidal ideations. Along with community outreach, suicide specialists are sent to area colleges in both Bronx and Westchester counties, town hall meetings, and yellow ribbon events to speak with our veterans about programs open to them. Awareness of the symptoms and having the hotline telephone number at easy reach are two ways we all can continue to help.

Telehealth Care

Kim Gibbs is the program manager for this program. Equipment has been installed at the medical center as well as the two CROCS. The hospital serves veterans in the Hudson Valley, Bronx, and Queens. The veterans are very receptive of this program and it saves both time and travel for many of the veterans who use this program. It is also ideal for elderly veterans who do not have to travel for diabetes testing and other medical testing or treatment, such as pulmonary, etc.

OIF/OEF/OND

Bianca Faber LSCS is the program manager, Jeff Colon-Melendez is the transition patient advocate, Tashany Myers R.N., Siobahn McKenny LCSW are the team members. The facility has a special office for this era of veterans. The goal is for same day initial consultations. The facility attempts to set up same day appointments whenever possible. Veterans seem to prefer receiving their initial care at the clinic and then integrate into the general population. The system at James Peters VAMC provides initial comfort for these veterans as they transition back to civilian life. The facility has an attractive and well equipped mobile van which attends college campuses, community events, and yellow ribbon events. Specialized staff attend many of these events. Enrollment and some equipment for testing have been added to the Van. The most common illnesses for these veterans is: PTSD, Substance abuse, and TBl issues. Emphasis has been placed on screenings and consultations along with recovery procedures. The facility has a good concentration of OIF/OEF veterans, but wants to encompass the entire veteran population for services. There is a transition care manager, who coordinates a team effort, along with care management through telephone calls, letters, and other communication techniques.

Facility Tour

Richard Joao is the Safety Manager and conducted the tour with Daniel Lee (Engineer and retired military veteran). The tour took us through a number of areas, where we were able to witness the use of a new radiation cleaner, which can clean a vacated room within ten minutes. This process also sterilizes the room, minimizing the spread of germs. Ml exam tables were facing away from doorways. The hospital was very clean and not dusty as reported in the IG report. While on tour, the team was able to visit the James Peters research facility for illness and rehabilitation. This part of the facility specializes in research for rehabilitation and mental health research. A display for quadriplegics was displayed, while a patient was learning to ambulate. This area was particularly clean and the staff very hospitable. They appear to take great pride in their accomplishments and research. The only area the team was unable to tour was the psychiatric inpatient floor, which is, of course, a locked and secured area.

Canandaigua VA Medical Center, Canandaigua, NY

Date: April 29-30, 2015
Task Force Members: P. Earle Gleason
Michael Boprey
William Wilkinson

Overview

Met with Lisa Wild from the Enrollment Office/Service Center; learned that the program is doing well. There have been Kiosks established for electronic check-in appointment time and are working well. There is paper operation for those receiving travel pay. CAVAMC has a fully equipped RV for out-patient visits in counties of Monroe, Wayne, Seneca, Ontario, and Livingston.

Access

OEF/OIF/OND Coordinator: The Task Force met with program manager Tammy Franklin on Tuesday April 30 in the AM. This area is serving approximately 300 veterans. The present staffing includes: a part-time social worker in the medical center and a full-time social worker in the Rochester Outpatient Clinic. Currently there is a plan to increase staffing level at the medical center with a new full time social worker.

Women Veteran Program

Met with Emily Sennett who is the Women's' Health and Sexual Trauma Coordinator. She is very motivated and concerned with the veterans she is serving. At this time there are no apparent needs in this program. Female doctor, Dr. Hoffman is handling women's' healthcare needs at the medical center. The women's' health care providers are looking into care for trans-gender veterans. Tammy Franklin is a strong supporter in this area and has done outreach and group meetings at St. John Fisher College, Rochester.

Mental Health

We met with Sarah Levis and Libby Louer Thompson. There are no long wait times or deficiencies. The medical center has a domiciliary unit with 48 beds. Interviews with several patients indicated the healthcare and treatment in general was great.

MST Coordinator

Met with Emily Sennett. See information under Women Veteran Program Manager.

Homeless Coordinator

We met with Erin Militello. There are 21 care-givers on this team and there has been some staff turn-over recently. Mental health and substance abuse cases are being coordinated with other available programs. The Safe Haven Project is a 15 bed unit available for veterans. They can live in this project for 6 months. Cadance Square, a similar project provides a 17 unit apartment building offering veterans supportive living for up to one year.

Patient Advocate

The Task Force met with Kelley Smith and Theresa George. Both of these staff members are enthusiastic and make certain that all veterans' problems are solved. There is adequate staffing at the present time.

Town Hall Meetings

The medical center goal is to have 4 town hall meetings throughout the year.

Future Challenges

- The current Director, Craig Howard, will be leaving the medical facility at the end of May, this year.
- Major construction in various planning stages which will include a state of the art nursing home.
- Extensive construction on the primary care and specialty clinics.

Rochester Out-Patient Clinic

Although productive in providing healthcare this clinic lacks space for many treatment programs requiring an overlap of clinic hours and parking is next to impossible. Major construction planning needs are not currently being met.

Suicide Prevention Center

We met with Director Julianne Mullane and toured this facility. The medical center houses the Veterans Crisis Line facility on their grounds. This facility is capable of receiving calls from any veteran in the world. This program is staffed 24/7, 365 days a year by staff who receive and handle phone calls dealing with veterans in distress. When a call is answered, the staff person stays on the line with the veteran in need until a complete resolution is established whether it be in the form of a medical center appointment; a call to law enforcement; or a needed call to First Responders. No call is

turned away or left unattended no matter the length of the call. The veteran is top priority with the staff member answering the call.

There are many challenges facing the facility and the staff. First, the facility is small and out of date concerning its overall network of computers, computer programs, telephone systems and lines. Next, the staff, although unquestionably dedicated, need continuous training, not only on how to help a veteran who calls for help, but to recognize the effects these calls have on them and other staff with whom they work.

VA Hudson Valley Healthcare System
Dates: **May 12-13, 2015**

Task Force Members: Daniel Morea
Louis Navarro
Wayne Southworth

Overview

The VA Hudson Valley Healthcare System includes the seven counties within the Hudson Valley. There are two campuses, Castle Point and the Franklin Delano Roosevelt (FDR) Campus, Montrose. The two campuses serve approximately 25000 veterans of a population of 150,000.

Castle Point Campus

The facility covers Dutchess, Westchester, and Orange Counties. The Castle Point Campus has been involved with extensive outreach to local college campuses. There is discussion of possibly implementing a liaison position to collaborate with various college campuses in the Hudson Valley to offer outreach and other military veterans VA services.

Town Hall Meeting

During our town hall meetings, several issues were brought to our attention. The call centers at both facilities and the CBOCs were slow to answer or never returned phone calls. Both campuses are scheduled to update their call center software and fill three positions that are vacant. Leadership continues to utilize the night shift (4 to 8PM) to make reminder calls for upcoming appointments resulting in less no shows. The Castle Point campus does not perform major surgery.

Non VA Billing Department

During the visitation a discussion on the VA choice card options and referral to private doctors were discussed. We were told further training for medical staff and support staff is forthcoming for clarification purposes. Concurrently, additional information will be provided to veterans to clear up any confusion concerning the Choice Program and fee-based, non-VA care.

Patient Advocate

The team visited with the patient advocate at both facilities. The Castle Point advocate, Ms. Khan, has been with the facility for ten years, while the advocate at Montrose has only six months experience. The team found an extreme variation in service, attitude, and enthusiasm from one facility to the other. The patient Advocates report to the Chief of UM quality management. I met with the Quality Management Director, and we discussed process, procedure, and tracking concerns. Various veterans service agencies contacted also do follow ups with the patient advocate or other appropriate supervision to assist veterans. It was agreed during our session, however, to encourage the use of the appropriate system to resolve issues.

IOF/OEF/OND

Mr. Angel Rosario is the Director of this program and was extremely interesting and informative. He has a well thought out game plan for this category of veteran. The team takes part in outreach at colleges and has a plan to meet with these veterans as they enroll for healthcare. Mr. Rosario appears to be an excellent advocate.

Long Term Care

We toured inpatient long term care buildings. There are two sections, Building H1 and H2, with very different ideologies. We were escorted by Danielle Gent (nurse manager) through H1. She and the entire staff had a very genuine and upbeat attitude, showing empathy and true caring for their patients. The patients, many of whom were in wheelchairs, seemed to enjoy their residency and found their care personalized with simple things like picture frames containing items from individual units, branch of service, etc. However, in stark contrast, the H2 block appeared to be less enthusiastic and not nearly as engaged with the patients.

Franklin Delano Roosevelt (FDR) Campus, Montrose

At the Montrose Campus we visited long term care, business office, OEF/OIF/OND, inpatient and outpatient services.

The leadership team discussed the scheduling and destruction of office buildings which, according to the Engineering Department have been in existence since the late 1940s and have been vacant without utilities for at least ten years. The buildings will be replaced with open space and outdoor activities for patients of the campus. Various Department heads of inpatient clinics indicated that the outdoor physical activities are an important tool to assist in the recovery and transition of veterans being treated for various mental health issues. The care and attention to the patients appeared to be involved and personalized

The one area that needs improvement is the Representative and delegates for VAVS. Dutchess County has agreed to request an additional deputy for Castle Point and the same will be requested for the Montrose campus. This will help ensure coverage when current representatives or deputies are no longer able to fulfill their duties.

Both facilities have received some supplement funding for special patient projects and they currently are able to keep up with patient care.

Our concern is that future caseloads for clinics will increase as patients return to the community and continuity of care. The Montrose campus does provide follow up contact three months and six months after inpatient stays. The team also discussed its desire for private buildings for female veterans for safety and security purposes. The facility currently has one building designed for females and a section of another building. Leadership also informed us that both Lyons, NJ and Canandaigua campuses have been designated for inpatient treatment for female veterans. Repeatedly, the administration spoke of increasing their female population to demonstrate the need for more local services.

Recommendations

Several areas of concern were displayed by staff and/or commented on during town hall meetings.
One crucial area concerned staff attitudes and the need for sensitivity training. Although not found to be common place, several staff seemed to have personal issues when trying to assist veterans which causes unneeded frustration for all involved.

Another area was the need for more volunteers to assist with an increase in volunteer services for veterans.

We also recommend a plan to have some of the town hall meetings and veterans workshops performed on either a Saturday morning or late afternoon/early evening to attract many young and employed veterans to participate in the town hall meetings and workshop to become more familiar with the services offered.

VA HEALTHCARE FACILITY VISITATION PROGRAM
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