July 31, 2008

Honorable James Peake, M.D.
Secretary
Department of Veterans Affairs
810 Vermont Avenue, NW
Washington, D.C. 20420

Dear Secretary Peake:

We the undersigned organizations write regarding our concerns about the proposed Denver, Colorado replacement medical center project you recently announced. As you are no doubt well aware we and our affiliates in Veterans Integrated Service Network (VISN) 19 that represent veterans and VA employees in the inter-mountain west, strongly oppose your plan as it stands today.

We have long supported and anticipated a critically needed replacement medical facility in Denver. We were particularly encouraged by the initial plan to replace this tertiary care, highly affiliated VA medical center, and to include expanded long-term care, additional mental health capacity, enhanced blind rehabilitation and a 30-bed spinal cord injury center as components of that new facility. After years of delay and the discarding of various unacceptable proposals we were encouraged that this project was finally proceeding through VA's programming, planning and design process, as well as progressing in the Congressional funding process.

It was with great dismay and alarm that we learned only in late April of VA's abandonment of the project (so-called "Project Eagle" as designated by VA), and that an alternative, and radically new approach would replace it. The announcement of this new approach came as a complete surprise to this community. If implemented it would eliminate the free-standing tertiary care VA medical center now operating in downtown Denver for the past 40-plus years, reduce the size and scope of long-term care and mental health programs from the pre-April plan, and egregiously would unacceptably bifurcate the spinal cord injury/dysfunction program into two different buildings hundreds of yards apart.

In your July 18 letters to Senator Salazar and Representative Perlmutter, you indicated that "…VA determined that this schematic design solution was not affordable…." In our community when we think of "not affordable," we think in terms of infantrymen lost in

combat, sailors lost at sea, veterans who suffer spinal cord injury, old veterans who need end-of-life care, and veterans, suffering from psychological stresses of combat, resorting to use of alcohol and drugs to self-medicate. At a time when no cost seems too great to bear on the deployed battlefields of Iraq and Afghanistan to support our troops, we question the determination of VA about what is "not affordable." Could you provide us an analysis that led VA to make this determination, including any external limiting factors that may have influenced the decision? Do you intend to apply the "not affordable" criterion to pending projects in Charleston, Las Vegas, Orlando, New Orleans and other future sites of VA major medical facility construction?

In addition to the above queries, we have posed numerous questions regarding the change, and, how your staff would envision a VA facility operating within the envelope of a major university academic health center to maintain its unique identity as a VA provider and continue to function independently within the guidance of existing VA directives, standards, procedures and history. After numerous discussions with VA representatives, we are still without definitive answers, but have often heard words such as these: "this will be worked out," "we can make it happen," "medicine is evolving and we are moving with the times," and "the details have yet to be worked out." Additionally, the newly proposed approach has continually been cast under the rubric of being "veteran centric" but to our knowledge without involvement by organizations that represent veterans.

At a time when VA health care has become the standard of excellence for American medicine, we must question why the sudden deviation from the existing model of care that has come to serve veterans so well. It is our collective view that the proposed plan for VISN 19 could dramatically alter the way VA provides care and diminish its capability to maintain the standard of excellence it now holds. Furthermore, we are gravely concerned that the new arrangement of utilizing leased space and relying on non-VA health care providers is a first step in the direction of privatization of veterans' care.

Our organizations and the Department of Veterans Affairs have had a long and collegial history in the development and evolution of systems of care for veterans. It is our hope to further this mutually beneficial relationship. To that end we are asking for your response to certain questions that we believe are paramount to the success of providing care in the future for veterans in VISN 19 and specifically aging veterans, veterans in need of mental health services, and veterans needing highly specialized health care resources for their challenges, including spinal cord injury and dysfunction, amputation, blindness, post traumatic stress disorder, substance use disorder, and other conditions prevalent in the veteran population. The information you provide will be of significant assistance to us as we further address the needs of our members and all veterans who will be served by VISN 19 health care.

An explicit example of our concerns is reflected in the proposed changes for the care and treatment of veterans with spinal cord injury and dysfunction. PVA's Architecture staff was working with VA on "Project Eagle" until its termination. It has been our experience that the involvement of PVA's architects contributed significantly to the success of VA's spinal cord injury system of care in all existing sites of care. To what degree will this relationship continue in VISN 19 and what assurances can you provide us that the requirements of existing

VA design standards will be adhered to, especially for those components of the project whose design falls within the jurisdiction of the university?

Additionally, VA and Paralyzed Veterans of America collaboratively developed the guidance for spinal cord injury care contained in the current VA Handbook 1176.1, which has benefited thousands of veterans in VA SCI/D units. The VISN 19 proposal appears to disregard Handbook 1176.1. How does the Department justify the abrogation of its own guidance to facilities? And, specifically it would be beneficial to learn the rationale for each deviation involved. Similarly, we would like to know how the staffing guidelines negotiated between Paralyzed Veterans of America and the Chief Consultant, Spinal Cord Injury and Dysfunction Strategic Health Care Group, would be maintained under the new proposed SCI/D unit.

Specific data regarding potential users of the new spinal cord injury center were originally based only on VISN 19 data detailing veterans' accessing care within the VISN. Subsequently new data were provided but without any elaborating or corroborating detail. Similarly, "Project Eagle" called for expansion of long-term care and mental health in-patient capacities, which have been reduced in this proposal. We would like to know exactly what projections VA is using, how the data were assembled and any other supporting documentation you believe would prove helpful to our understanding.

Finally, we would like to know how and why the decision was made to jettison CARES as a road map for VA's future requirements, along with any demographic and health utilization data developed to support your decision. The veterans' community expended significant effort and resources in working with VA to ensure health care for veterans would be available and appropriately sited in the future; CARES was the end result. Were any non-VA elements involved in the decision-making process to move away from CARES, notably consultants, academic affiliates or other entities of government? If so, we request that you provide us with any materials obtained from these non-VA elements, and how those elements influenced your decision.

Let it be clear that we strongly support improvements in other aspects of the inter-mountain VA system of care, a number of which initiatives were brightly identified in the CARES process as necessary to improve VA health care access in Colorado Springs and Grand Junction, Colorado; in Cheyenne, Wyoming; in Helena and Billings, Montana, and in other areas of VISN 19. We appreciate VA's intentions to expand its services in those areas. But we disagree in the strongest of terms that these improvements should come at the expense of veterans who have been using the Denver VA Medical Center for half a century. Can you provide us any data that validates that veterans in Cheyenne, Wyoming, for example, are traveling to Denver in the numbers and with the regularity that justify unbundling the existing Denver resource base and moving it to Cheyenne?

Your prompt response to our concerns will go a long way in reinforcing the spirit of cooperation that has characterized our relationship with VA for decades. Also, it will greatly assist us in assessing the VA's further intentions as they relate to future health care for sick and disabled veterans who use VA today and will do so tomorrow.

Sincerely,

Jim King
Executive Director
AMVETS

David Gorman
Executive Director
Disabled American Veterans

Homer S. Townsend, Jr.
Executive Director
Paralyzed Veterans of America

Bob Wallace
Executive Director
Veterans of Foreign Wars

Thomas Miller
Executive Director
Blinded Veterans Association

Rick Weidman
Director of Government Relations
Vietnam Veterans of America

Marilyn Park
Legislative Representative
American Federation of Government Employees

cc: Honorable Gordon H. Mansfield
Deputy Secretary