

**PROVIDING CARE FOR RURAL VETERANS:
COMMUNITY-BASED OUTPATIENT CLINICS**

HEARING

BEFORE THE

COMMITTEE ON VETERANS' AFFAIRS

UNITED STATES SENATE

ONE HUNDRED ELEVENTH CONGRESS

FIRST SESSION

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AUGUST 26, 2009
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Printed for the use of the Committee on Veterans' Affairs



Available via the World Wide Web: <http://www.access.gpo.gov/congress/senate>

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U.S. GOVERNMENT PRINTING OFFICE

53-063 PDF

WASHINGTON : 2010

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PROVIDING CARE FOR RURAL VETERANS: COMMUNITY-BASED OUTPATIENT CLINICS

WEDNESDAY, AUGUST 26, 2009

U.S. SENATE,
COMMITTEE ON VETERANS' AFFAIRS,
Jesup, GA.

The Committee met, pursuant to notice, at 2:35 p.m., in C. Paul Scott Polytechnical Center, Altamaha Technical College, Jesup, Georgia, Hon. Johnny Isakson, presiding.

Present: Senator Isakson.

OPENING STATEMENT OF HON. JOHNNY ISAKSON, U.S. SENATOR FROM GEORGIA

Senator ISAKSON. Good afternoon and welcome. I am U.S. Senator Johnny Isakson and I am delighted to be here. I want to thank the Technical College and their President for all their cooperation and hospitality in allowing us to hold this hearing today.

Before I get into my opening remarks, I want to say to all our veterans that are in the audience today, first of all, on behalf of all Georgians and all Americans, we thank you for your service. One of the reasons that I asked to be on the Veterans Committee when I was elected to the Senate was because I wanted to do everything I could to see to it that the promises made to our veterans were delivered, and everywhere we could improve veterans services, we would do that. Community-Based Outpatient Clinics are certainly one of those areas where that is taking place, and that is the purpose of this hearing today. Most importantly, on behalf of all the people of our country and of this State, we want to thank you for your service and your sacrifice for the United States of America.

On community-based outpatient clinics: 1922 is when the first service to our veterans who came home took place, and it was generally—it was always a patient-based hospital service. And then in 1994, in Amarillo, Texas, a change took place and VA converted to—they didn't convert from hospitals to community-based clinics, but began opening community-based clinics around the United States. Today, there are over 700 community-based clinics in the United States of America serving our veterans.

A while back, there was a proposal made by the administration and the Department of Veterans Affairs to open two new clinics in this part of Georgia—one in Hinesville and one in Glynn County—and that is substantially the purpose of this meeting today.

Now, I am aware that both of those clinics have been somewhat delayed—Hinesville for very obvious reasons. The Veterans Administration decided after determining we needed an expanded clinic

here, and what was originally thought to be a 10,000 square-foot outpatient center is now planned to be, as I understand it—and I will be corrected by our witnesses, I am sure, if I am wrong on this—a 25,000 square-foot outpatient facility, including mental health services.

As everyone knows, there is a tremendous challenge in the Gulf War, the wars in Afghanistan and Iraq, for those returning with PTSD or TBI. I have personally had the privilege of seeing the marvelous work that the Augusta Uptown VA and the Eisenhower Medical Center in Augusta have done to create a seamless transition for our veterans going from DOD into veterans health care, to see the many people who came out of the war with TBI or PTSD who have been remediated, have been treated, and are back in society—as we want everybody to possibly be. So, the expansion of that clinic precipitated somewhat of a delay.

Glynn County: I am not sure I know exactly why, and I am sure part of the testimony will be to answer that, as well; but we have a substantial and significant number of veterans in this part of Georgia, in no small measure because of the facilities at Kings Bay in Camden County and Fort Stewart in Liberty County. We want to make sure that the services to our veterans are complete, and that in terms of health care, it is reachable or within the reach of every single veteran.

The change in 1994 at Amarillo reflected the change in both injuries as well as the need for services, and it is now a lot easier in Georgia for a veteran to get service at a clinic rather than having to drive to either Dublin, Atlanta, or Augusta, which are the location of the three hospitals. I want to personally thank the Veterans Administration for the outreach they have provided and for the investment they have made in Georgia and the clinics we have been able to open since I was elected to the U.S. Senate, for which I take no credit except to be a part of. I thank the Veterans Administration for having done that and for what they have done in it.

I want to introduce a couple of staff members who are with me today. Lupe, raise your hand. Lupe is the brains of the operation. I am just the front man. And Chris—Chris is the VA staff person in my office. They will be here to assist me today.

We have passed out three-by-five cards. After the testimony and the questioning that I will give, if you will pass those forward or give them to one of my people. Nancy Bobbit is here in the back. She will collect them if you have a question, and I will ask those questions of our panelists if we have time. That will be in the off-the-record program after the testimony of this field hearing today from panel one and from panel two.

With that said, let me invite our first panel to come forward. Joe Williams, the Deputy Under Secretary for Health, Operations, and Management.

Lawrence Biro—did I pronounce it right? I do it wrong every time. I said it wrong when you were in Washington, I know, and I apologize. It is only four letters. I ought to be able to get that right. He is the Director of Veterans Integrated Service Network.

Rebecca Wiley, Director of the Charlie Norwood VA medical center. I have already bragged in my opening remarks about the Charlie Norwood Center once, but I want to brag about them again.

They were featured on “NBC Nightly News” about 2 months ago because of the miraculous and marvelous work that they are doing. And as long as I am able to serve in the U.S. Senate, I am going to attempt to see to it that whenever we have a DOD facility and a veterans facility in the same city, that they can replicate what has been done in Augusta, Georgia. It is truly a great service to our veterans and I congratulate you on that.

I don’t know what order you were told, but my mother raised me that ladies were always first, so Rebecca? If you will, try to keep your remarks to around 5 minutes; but if you go over, that is fine. We will take your testimony first.

Ms. WILEY. Thank you, sir. I am going to defer to Mr. Williams.

Senator ISAKSON. OK. I am sorry, Mr. Williams, but she is a lot prettier than you are, so I wanted her to go first.

Mr. WILLIAMS. Yes, sir, and I am glad you recognize that. [Laughter.]

Senator ISAKSON. I am old, but I am not that old.

Mr. Williams?

STATEMENT OF JOSEPH WILLIAMS, DEPUTY UNDER SECRETARY FOR HEALTH, OPERATIONS AND MANAGEMENT, VETERANS HEALTH ADMINISTRATION, U.S. DEPARTMENT OF VETERANS AFFAIRS; ACCOMPANIED BY LAWRENCE BIRO, NETWORK DIRECTOR, VETERANS INTEGRATED SERVICE NETWORK 7, U.S. DEPARTMENT OF VETERANS AFFAIRS; AND REBECCA WILEY, DIRECTOR, CHARLIE NORWOOD VA MEDICAL CENTER

Mr. WILLIAMS. Mr. Chairman, thank you for the opportunity to appear before you today to discuss the Department of Veterans Affairs’ health care and facility issues in Georgia.

I am accompanied today by Mr. Lawrence Biro, the Network Director for the VA Southeast Network, VISN 7, and Ms. Rebecca Wiley, the Director of Charlie Norwood (Augusta) VA Medical Center.

Today, my testimony will address the process by which VA determines where to build new Community-Based Outpatient Clinics, how such clinics are built, and the services that they provide. I will also discuss how VA provides care to veterans in Georgia. Thanks for providing this opportunity to us to address these important issues and for your continued support of our veterans.

VA determines its health care and benefits infrastructure requirements through a strategic planning process that is closely linked to the Department’s missions and goals. VA is further committed to further improving the access to health care for veterans, including veterans in rural areas, by comprehensively evaluating demographics in the market, determining clinical need for services in the area, and then aligning capital investment strategies to meet the health care needs of those veterans. VA carefully analyzes utilization trends. We look at our veteran population and the enrolled users to ensure that the appropriate mix of services is available to meet the needs of our local veterans.

Over the last few decades, CBOCs have shown to be effective in improving access to care for our veterans and assist us in providing a high quality of care in a cost-effective manner. The Veterans

Health Administration plans to continue meeting those comprehensive health care needs for veterans nationwide by establishing new CBOCs, new outreach clinics, mobile clinics utilizing state-of-the-art technology to bring care closer to our veterans' home, and using resources within the communities when clinically necessary. By the end of the fiscal year 2010, VA plans to operate 833 CBOCs, and that will be 78 more than we had active in 2008.

CBOCs are developed through a methodology that partners Central Office with our VISNs. This allows the decisionmaking with regard to CBOCs and the needs and the priorities to be made in the context of future and local markets and those market circumstances. The methodology evaluates the convergence of geographic access as measured by drive-time guidelines for primary care services and projected demand for primary care and mental health services, as well. The methodology drives the initial step in VHA's national CBOC deployment plan.

A comprehensive business plan is required to submit an application, and several alternatives are reviewed within this business plan and these alternatives include renovations of the existing facility. It may include construction of a new facility, procuring a lease for space, or contracting within for community resources. These are all things that we look at to address the health care gaps as we move the CBOC application forward.

Once the analysis is completed and the access gaps are identified, VISNs will determine if a CBOC will best meet the needs of the veterans in that particular area. The VISN will then submit a Business Plan to VA Central Office for review by a panel of experts. The review considers much of the following criteria: the quality and need of the proposal; the location in the market not meeting VA access guidelines; they will look at the quantity of users and enrollees, and market penetration. There will be considerations for unique things, included in the proposal: how their proposal improves access for minority veterans; how it overcomes geographic barriers; or reaches out to the medically underserved areas. Cost effectiveness and the impact on waiting times is also looked at as part of that review criteria.

VA uses both a VA personnel management model and a contracting model when we consider staffing our CBOCs. The VA personnel management model ensures direct accountability of staff to VA managers, direct coordination of care and services with other VA programs. It delivers more efficient records management in a VA-staffed CBOC. It ensures DOD and VA collaboration at a higher degree, and education and teaching opportunities that we can all leverage and benefit from.

The contracting operations management model is used generally in areas where the veteran population is small, and we see some of those particularly in some of the smaller rural areas. The contract operation model must meet VA's quality and patient safety standards, and is cost effective because it allows VA to take advantage of existing community resources where the numbers are small.

Georgia is supported by two VISNs, the VA Southeast Network, which is the VISN 7, and the VA Sunshine Health Care Network, which is Network 8. Although the latter extends into the Southeastern portion of the State, VISN 7 provides services to veterans

in South Carolina, Georgia, and Alabama. There are an estimated 1.46 million veterans living within the boundaries of VISN 7 in fiscal year 2008, and 457,000 veterans are enrolled in that health care system.

VISN 7 includes eight VA medical centers or health care systems based in Augusta, Georgia; Atlanta, Georgia; Dublin, Charleston, South Carolina; Columbia, South Carolina; Birmingham, Alabama; Tuscaloosa; and the Central Alabama Veterans Health Care System, which have locations in Montgomery and Tuskegee.

In fiscal year 2008, the network provided services to about 328,000 veterans out of the 457,000 enrolled. There were about 3.56 million outpatient visits and a total of 30,335 hospital inpatient discharges. The cumulative full-time employee level for this network was 12,678, and the operating budget was over \$2.1 billion.

Six of our VA medical centers or health care systems have robust research programs and each has been fully accredited by the Association of Accreditation for Human Research Protection Programs. These facilities also have their own research compliance officer. Some highlights of the research being done in VISN 7 include Rehabilitation Research Center of Excellence in Atlanta and Geriatric Research Education and Clinical Centers in Atlanta and Birmingham.

Specialty services are also available at a number of our facilities. For example, both Augusta and Birmingham offer blind rehabilitation services. Augusta is home to a spinal cord injury unit program. Central Alabama, Tuscaloosa, Atlanta, and Birmingham offer residential rehabilitation treatment programs. Augusta, Central Alabama, and Dublin provide domiciliary support, and all VA medical centers in VISN 7 have women's veterans programs.

Access to care is a priority in VISN 7. Between fiscal year 2009 and fiscal year 2010, we are opening four new CBOCs in Georgia alone to support that.

Georgia is a home to three VA medical centers, Augusta, Atlanta, and Dublin. The Atlanta facility employs 2,500 full-time employees and served more than 65,000 unique patients in fiscal year 2008. More than 3,500 of those who served in Operation Enduring Freedom and Operation Iraqi Freedom were served by this facility. Augusta employs more than 2,100 people and serves more than 38,000 uniques and provided care to 2,400 OEF/OIF veterans in 2008. Dublin, which has been designated as a rural access facility, employs approximately 850 full-time employees and serves approximately 28,500 veterans. This includes over 1,600 OEF/OIF veterans or patients in 2008. The three facilities provide approximately 660,000, 360,000, 190,000 outpatient visits, respectively.

There are currently 15 active CBOCs and primary care clinics in Georgia and four more are scheduled to open by the end of 2010. The Committee has expressed interest in two specific CBOC projects, Brunswick and Hinesville. The Brunswick CBOC is currently in the lease advertisement process for clinic space. VA will evaluate the offers received, which will include site selection. Proposals were due by July 31, and VA is in the process now of reviewing those responses. VA currently expects to open the clinic sometime in February 2010.

Regarding the Hinesville market area, VA has a space plan under review by VA Real Property Service that will likely require approval by the Secretary. VA currently estimates the Hinesville CBOC to be activated around October 2011.

In summary, with the support of the Senate Committee on Veterans' Affairs and the Georgia Congressional delegation, VA is meeting the health care needs of veterans in the area.

Again, Mr. Chairman, we want to thank you for the opportunity to testify today at the hearing. My colleagues and I are available to address any questions that you may have for us.

[The prepared statement of Mr. Williams follows:]

PREPARED STATEMENT OF JOSEPH WILLIAMS, RN, BSN, MPM, ACTING DEPUTY UNDER SECRETARY FOR HEALTH FOR OPERATIONS AND MANAGEMENT, VETERANS HEALTH ADMINISTRATION, U.S. DEPARTMENT OF VETERANS AFFAIRS

Mr. Chairman and Members of the Committee, thank you for the opportunity to appear before you today to discuss Department of Veterans Affairs (VA) health care and facility issues in Georgia. I am accompanied today by Mr. Lawrence Biro, Network Director, VA Southeast Network (Veterans Integrated Service Network [VISN] 7) and Ms. Rebecca Wiley, Director of the Charlie Norwood (Augusta) VA Medical Center (VAMC).

Today, my testimony will address the process by which VA determines where to build new community-based outpatient clinics (CBOC), how such clinics are built, and the services they provide. It will also discuss how VA provides care to Veterans in Georgia. Thank you for providing this opportunity to address these important issues and for your continued support of America's Veterans.

COMMUNITY-BASED OUTPATIENT CLINIC SELECTION PROCESS

VA determines its health care and benefits infrastructure requirements through a strategic planning process that is closely linked to the Department's mission and goals. VA is committed to further improving access to health care for Veterans, including Veterans in rural areas, by comprehensively evaluating demographics in a given market, determining the clinical need for services in the area, and then aligning capital investment strategies to meet the health care needs of Veterans in the area. VA carefully analyzes utilization trends, Veteran Population (VetPop) data, and enrolled users to ensure that the appropriate mix of services is available to meet the needs of local Veterans. Over the last decade, CBOCs have shown to be effective in improving access to care for Veterans and providing high-quality care in a cost-effective manner. The Veterans Health Administration (VHA) plans to continue meeting the comprehensive health care needs of Veterans nationwide, by establishing new CBOCs, outreach clinics, mobile clinics, utilizing state-of-the-art technology to bring care closer to the Veteran's home, and using community resources when clinically necessary. By the end of fiscal year (FY) 2010, VA plans to operate 833 CBOCs, 78 more than were active in FY 2008.

CBOCs are developed through a methodology that partners VA's Central Office and VISN staff. This allows decisions regarding CBOC needs and priorities to be made in the context of current and future local market circumstances. The methodology evaluates the convergence of geographic access as measured by drive-time guidelines for primary care services and projected demand for primary care and mental services. The methodology drives the initial step in VHA's national CBOC deployment plan. Comprehensive business case applications are submitted that provide several alternatives (including renovation of an existing facility, construction of a new facility, procuring a lease, or contracting with community resources) to address any health care gaps.

Once the analysis is completed and access gaps are identified, VISNs will determine if a CBOC will best meet the needs of Veterans in the area. The VISN will submit a Business Plan for the CBOC to VA's Central Office for review by a panel of experts. This review considers the following criteria:

- Quality and need of the proposal
- Location in a market not meeting VA Access Guidelines
- Quantity of users and enrollees
- Market penetration

- Unique considerations, including whether the proposal improves access for minority Veterans, overcomes geographic barriers, or reaches out to medically underserved areas
- Cost effectiveness and
- Impact on waiting times

VA uses both the VA personnel management model and contracting operation management model to staff CBOCs. The VA personnel management model ensures direct accountability of staff to VA managers, direct coordination of care and services with other VA programs, delivers efficient records management compliance, DOD and VA collaboration, and education and teaching opportunities. The contract operations management model is used generally in areas where the Veteran population is small, particularly in rural areas. The contract operation model must meet VA's quality and patient safety standards and is cost effective because it allows VA to take advantage of existing community services.

VISN SUPPORT IN GEORGIA

Georgia is supported by two VISNs: VA Southeast Network (VISN 7) and VA Sunshine Healthcare Network (VISN 8), although the latter extends only into the southeastern portion of the state. VISN 7 provides services to Veterans in South Carolina, Georgia and Alabama. There were an estimated 1.46 million Veterans living within the boundaries of VISN 7 in FY 2008, and 457,349 Veterans were enrolled in VA for health care.

VISN 7 includes eight VA medical centers or health care systems based in Augusta, GA; Atlanta, GA; Dublin, GA; Charleston, SC; Columbia, SC; Birmingham, AL; Tuscaloosa, AL; and the Central Alabama Veterans Health Care System (locations in Montgomery, AL and Tuskegee, AL). In FY 2008, the Network provided services to about 328,000 out of more than 457,000 enrolled Veterans. There were about 3.56 million outpatient visits and 30,335 hospital inpatient discharges. The cumulative full-time employee level was 12,678, and the operating budget was about \$2.1 billion.

Six of our VAMCs or health care systems have robust research programs, and each has been fully accredited by the Association for the Accreditation of Human Research Protection Programs (AAHRPP). These facilities also have their own research compliance officer. Some highlights of the research being done in VISN 7 include a VA Rehabilitation Research Center of Excellence in Atlanta and Geriatric Research Education and Clinical Centers in Atlanta and Birmingham. Specialty services are available at a number of our facilities. For example, both Augusta and Birmingham offer Blind Rehabilitation Services; Augusta is home to a Spinal Cord Injury (SCI) program; Central Alabama, Tuscaloosa, Atlanta and Birmingham offer Residential Rehabilitation Treatment Programs; Augusta, Central Alabama and Dublin provide domiciliary support; and all VA medical centers in VISN 7 have women Veterans' programs. Access to care is a priority in VISN 7, and between FY 2009 and FY 2010, we are opening four new CBOCs in Georgia alone.

GEORGIA HEALTH CARE FACILITIES

Georgia is home to three VA medical centers: Augusta, Atlanta, and Dublin. The Atlanta facility employs approximately 2,500 full-time employees and served more than 65,000 unique patients in FY 2008, more than 3,500 of whom served in Operation Enduring Freedom or Operation Iraqi Freedom (OEF/OIF). Augusta employs more than 2,100 people, serves more than 38,000 unique patients, and provided care to 2,400 OEF/OIF Veterans in FY 2008. Dublin, which has been designated a rural access facility, employs approximately 850 full-time employees and served approximately 28,500 Veterans (including over 1,600 from OEF/OIF) in FY 2008. The three facilities provided approximately 660,000, 360,000, and 190,000 outpatient visits respectively.

There are currently 15 active CBOCs and primary care clinics in Georgia, and four more are scheduled to open by the end of FY 2010. The Committee has expressed interest in two specific CBOC projects: Brunswick and Hinesville. The Brunswick CBOC is currently in the lease advertisement process for clinic space. VA will evaluate offers received which will include site selection. Proposals were due by July 31, 2009, and VA is reviewing these responses. VA currently expects to open the clinic in February 2010.

Regarding the Hinesville market area, VA has a space plan under review by VA Real Property Service that will likely require approval by the Secretary. VA currently estimates the Hinesville CBOC will be activated in October 2011.

CONCLUSION

In summary, with the support of the Senate Committee on Veterans' Affairs and the Georgia Congressional delegation, VA is meeting the health care needs of Veterans in the area. Again, Mr. Chairman, thank you for the opportunity to testify at this hearing. My colleagues and I are available to address any questions you may have for us.

Senator ISAKSON. Well, thank you very much, Mr. Williams. I appreciate your testimony, and I want to make note, by the end of this year, we will have 78 more clinics—833—is that right?

Mr. WILLIAMS. Yes, sir.

Senator ISAKSON. That is an outstanding condition.

With regard to Brunswick, my understanding is there was an RFP put out for that clinic. It came in. You all made a decision, then you decided to reopen it and you are just now in the process of making a final decision on a site, is that correct?

Mr. WILLIAMS. Yes, sir. I will defer to Mr. Biro for comments.

Mr. BIRO. Yes, that is right. There was a technical flaw in the bidding process that we had to resolicit the bid. We got back several offers and we plan to move ahead on that right now.

Senator ISAKSON. Will this be a leased facility?

Mr. BIRO. The building itself, yes, will be a leased facility.

Senator ISAKSON. With regard to Hinesville, I think the testimony of Mr. Williams said probably the fall or October 2011 would be the target date. Is that meetable? Is that target meetable?

Mr. BIRO. That is a very conservative date. The problem there is the belief that there isn't a suitable building in the Hinesville area, at least with our real estate people right now. We just rode over from Charleston and we kind of feel that, looking a little harder, we may find a building that would be appropriate for a veterans clinic. We are also thinking of starting maybe—doing some outreach there a little bit earlier, as early as we can. But right now, the 2011 date, based on the size of the lease, requires many more approvals.

Senator ISAKSON. I would like to ask you to consider doing something in Hinesville, if you don't mind. As you probably are aware, the Secretary of the Army recently pulled back on a previous commitment to move a brigade combat team to Fort Stewart. The community has made a significant investment in additional facilities in anticipation of the brigade combat team coming. I don't know if any of those facilities would be appropriate for a veterans clinic, but I think there is an obligation on behalf of the country, because of pulling that commitment, to do everything they can to make that community whole.

So, I would like to personally ask if you would make sure that you reach out to the banks and the development community who have put in over \$400 million in investments in the Hinesville-Fort Stewart area in anticipation of that combat team coming, which is now not coming. If there was a building that was suitable and the VA could lease it for that purpose, it would be a win-win proposition for the VA and certainly help that community that is going to struggle because of the pull-out of that commitment by Secretary Gates. So, if you would promise me you would make that consideration, I would very much appreciate it.

Mr. BIRO. Yes, I will. I will make contact immediately and do the market survey there.

Senator ISAKSON. Mr. Williams, did I understand correctly that in Regions 7 and 8, there are 1.4 million veterans, or in just Region 7? Do you remember?

Mr. BIRO. Can I answer that? That is just VISN 7.

Senator ISAKSON. Just VISN 7. And 457,000 are enrolled in care?

Mr. BIRO. That is enrolled, yes.

Senator ISAKSON. And you treated—what was the number you actually treated?

Mr. BIRO. Roughly over 300,000. I think it is 324,000. But it is over 300,000.

Senator ISAKSON. Mr. Biro, you are responsible for the Atlanta hospital, are you not?

Mr. BIRO. Yes.

Senator ISAKSON. OK. This hearing is not about the Atlanta hospital, but I think I have an obligation to ask a question about it, too, particularly on behalf of our veterans. The hospital is going through a renovation and an expansion, which I was proud to help procure the money for. But the Clairmont Road facility and the need for construction has significantly restricted parking for veterans going for services. I want to thank the hospital publicly for the efforts they have made in terms of shuttles and other things, but are we making some improvement in accessibility, to your knowledge, for those veterans that go there for services?

Mr. BIRO. The remote parking—we are making progress with that. We ran into one little glitch about how we can transport people, but we are making progress. We do have on the plans, which would not be real immediate, a parking structure in the front of that building where the parking lot is, which would then alleviate the parking problems. So we are working on it in as many ways that we can.

Besides being the Network Director, I am a veteran and I do get my services at Atlanta. I frequently joke that if I saw that parking problem, I would drive by. I have a spot, so I can park. But yes, that is an issue I am very sensitive of.

Senator ISAKSON. I appreciate that. I don't want to interrupt my questions, but would the Mayor of Hinesville who just arrived stand up? Didn't I see him come in back there? I want the record to reflect that I have already asked for the VA to consider utilizing the existing facilities that Hinesville has prepared that were in anticipation of the brigade combat team for its lease operation be considered for its veterans clinic, Mr. Mayor. So, I wanted to let you know we have already looked out for you. Thank you, sir, and thank you for what you do, Mayor.

Ms. Wiley, I always brag about what you all do there. It is nothing short of remarkable. How is the progress coming with the seamless transition, and how is the rate of cures in terms of TBI progressing?

Ms. WILEY. Well, thank you, Senator, for your continued support of our program. We are very proud of it, too. At this time, we continue to have a very strong relationship with the DOD, and this year already we have treated approximately the same number of active duty soldiers through our rehab and TBI program that we

treated for the total year last year. So we continue to see a very strong relationship.

We have also initiated another program through our domiciliary—our TRRP program—and that was a pilot program this last year. We have had tremendous success with treatment of patients with specific TBI-related diagnoses who did not need hospital-level care, but needed domiciliary type of care. I believe that our results to date have been approximately a 35 percent return to duty rate for those soldiers. So, it is our aim for the coming year to continue to explore ways to work with the DOD, not only at Fort Gordon, but expand that a bit in the Southeast to offer that service for other soldiers.

Senator ISAKSON. If I am not mistaken, not only is the return rate now at 35 percent and improving, but a lot of those people are returning actually to the theater of operations in Afghanistan or Iraq. Is that not correct?

Ms. WILEY. That is correct, sir. I am just not sure of the 35 percent—how many of those return to the theater.

Senator ISAKSON. Well, it is a great credit to Augusta. When I had the field hearing at Augusta, I guess it has been 2 years ago now—it may have been last year—I met a Sergeant Harris as I was touring the facility, and if you remember, she turned the corner. She had been hit with an IED her second day in Iraq and had suffered from TBI. She came back, was assigned to veterans and dismissed from the military. You all turned her around at the clinic and she was reenlisting and was going back to Iraq, which is a great testimony to what you are doing there at the Augusta center.

At the Augusta facility, there was an incident with regard to either endoscopy or colonoscopy in terms of equipment and sterilization. Has that been addressed?

Ms. WILEY. Absolutely, sir. Our situation regarding reusable medical equipment had to do with endoscopies, which is the device that is used to go down the nose or the throat. Since that time, we have instituted a complete revision of all of our standard operating procedures, all of our processes for reusable medical equipment, and we have been surveyed externally and internally numerous times in the last 2 months and have had 100 percent results from those surveys.

Senator ISAKSON. Mr. Williams, on that subject, has that incident resulted in a change within the system to ensure a redundancy in terms of sterilization?

Mr. WILLIAMS. Yes, sir. The changes that Ms. Wiley spoke to are not only changes that are happening at the Augusta facility, but they are happening across the country. Our network directors and medical center directors all took aggressive actions to move forward to assess where they were with regards to standard operating procedures and outcomes. We deployed managers, leaders, teams across the country to assess all of our facilities.

From that, and I am sure you are aware that a recent review by the IG teams that went out indicated that we had substantial compliance with the standards. Not only did we demonstrate that we had addressed those issues that had been identified, that we had actually moved beyond and were learning new things and taking opportunities to make even more efficiencies occur, such as limiting

the number of places where we perform these procedures, standardizing our standard operating procedures at medical centers, re-addressing our training and education.

So, yes, sir, we have looked at this from a systems standpoint and we are demonstrating that type of improvement in compliance across the country.

Senator ISAKSON. Thank you for that answer.

In your testimony, when you talked about where you place—the criteria you go by to place an outpatient clinic, you mentioned quality, access guidelines, market penetration, and the medically underserved.

Mr. WILLIAMS. Yes, sir.

Senator ISAKSON. And when I heard you talk about the medically underserved, I heard you mention that the preponderance of your contract providers were in medically underserved clinics. Is that correct? Did I hear you say that, or was I not—

Mr. WILLIAMS. I don't recall.

Senator ISAKSON. Well, let me ask the question another way and maybe Mr. Biro would want to answer it. Of our 800, or soon to be 833 outpatient clinics, how many of the providers are staff VA providers and how many of them are contract providers?

Mr. WILLIAMS. I don't have that specific information, but we can provide that for you.

Mr. BIRO. We will have to take it for the record.

Senator ISAKSON. Do you have just a ballpark guess?

Mr. BIRO. I think only about two out of the ones in Georgia—

Senator ISAKSON. Are contract?

Mr. BIRO [continuing]. Are contract, yes.

Senator ISAKSON. OK. Thank you very much.

I am going to ask the question I have been handed, but I don't know if I understand the question or not. What is the potential for VA/DOD collaboration at the Hinesville clinic?

Mr. BIRO. It is great. We are already working with Fort Stewart. We have people there already as liaison. We are already doing the discharge or exit physicals there. We will certainly talk to the Commander of the hospital there on how we can cooperate.

Senator ISAKSON. Well, let me ask you this question with regard to Uptown VA in Augusta and Eisenhower. The closest hospital, I guess, to Hinesville would be Dublin?

Mr. BIRO. That is right. The Hinesville facility is going to be run by the Charleston VA.

Senator ISAKSON. By Charleston? Is it—

Mr. BIRO. Right, Charleston, South Carolina.

Senator ISAKSON. I know proximity is essential to what you all have done in Augusta, Ms. Wiley, but is it possible to adopt some of the seamless transition procedures they have done in Augusta in this new Hinesville facility with Charleston?

Mr. BIRO. Yes. Yes. Like I said, we are doing the separation physicals now; at least we are coordinating them and we are in the process of doing even more. So, we will make sure that that continues to work.

Senator ISAKSON. I think Secretary Shinseki has been very impressed with what has happened there and I think the results bear out that this is an important thing to cover.

Two questions. Ms. Wiley, let me ask you this question. You have been at Augusta long enough to make a determination since the Warrior Transition Centers were upgraded, the beginning of the upgrade here was about, I guess, 18 months ago. Are the Warrior Transition Centers helping in terms of the condition of the veterans who come out of DOD and into VA health care? Is that a loaded question?

Ms. WILEY. Yes, it is, sir.

Senator ISAKSON. OK.

Ms. WILEY. What I can tell you—

Senator ISAKSON. Well, give me a loaded answer.

Ms. WILEY. What I can tell you that I observe is maybe not an answer that could be applicable to everywhere else, because in Augusta, we have such a close relationship with the Warrior Transition Unit and the VA. We have a lot of interconnectedness that occurs that is unique to our situation, and because of that, the positive working relationship that we have—because of the active duty unit—also translates to a very positive working relationship as we are transitioning soldiers back into veteran status.

Senator ISAKSON. Second question. With regard to the Transition Centers. I was struck, when I went through the center at Fort Stewart last year, by the number of women that were going through the Warrior Transition Center; and unlike TBI and PTSD, many of their problems were orthopedic, in particular because of the weight of the equipment that many of them were carrying on the battlefield. Was that a correct observation, number 1, on my part? And number 2, what are we doing to address that in terms of their care?

Ms. WILEY. Well, again, I could tell you what we are doing in Augusta as soldiers become veterans. We have established a women's clinic that opened in April—

Senator ISAKSON. Great.

Ms. WILEY [continuing]. Specifically to address women's needs, and we have a gynecologist and a practitioner who is devoted to the women's clinic. We also have a relationship with Eisenhower regarding mammography services and work collaboratively with them on all of our women's needs.

Senator ISAKSON. Was I correct in my observation about orthopedic problems, or is it more of other types?

Ms. WILEY. I can't tell you that for sure, but I will find that out for you.

Senator ISAKSON. I wish you would, because when I was with the people at Fort Stewart, that specifically was the question I asked. It appeared to me there were a disproportionate number of women in the center versus the ratio in the service and I asked the question, why? And the immediate answer was, because of the orthopedic difficulties from weights and things like that. So, check into that for me and let me know.

With regard to the underserved and rural care, we now have 11 community-based clinics now, right? No, that is wrong. We have 15 going on 19 in Georgia, is that correct?

Mr. BIRO. Yes.

Senator ISAKSON. Can you tell me, Mr. Biro, about how that affects accessibility for the average veteran? I mean, we are in a

technical college in Georgia and we like to say that we have a technical education center within 45 minutes of every student that wants technical education. Are we getting to a point that our veterans have reasonably quick access to outpatient clinics if they don't go to the hospital?

Mr. BIRO. We are getting there. We are working on this. We have this formula, as Mr. Williams had pointed out, that there be no more than a particular length of commuting time. It is about 30, 60, or 90 minutes, depending upon saturation. So, we have a map and we are turning that map green by—the map is gray, and as we put new clinics in, it turns green, showing that the clinics are close enough. Are we finished? No, but we are making progress. We are making a lot of progress.

Senator ISAKSON. Thirty to 90 minutes is great progress compared to three hospitals and no clinics, which was the case just a few years ago. So, I commend you on what you are doing and continuing to do.

I am going to summarize—unless somebody behind me reminds me of something I forgot to ask—by talking about a couple of things I had mentioned earlier. One, we thank you very much for the emphasis on Glynn County and Brunswick and the emphasis on Hinesville. I think both of the answers were that the opening of Brunswick in 2010 and the opening of Hinesville in late 2011 are conservative estimates, which means it might happen sooner and we certainly hope that takes place.

But also with regard to Hinesville, I want to repeat what I said earlier. I sincerely hope the administration will consider looking at those facilities that have been built in preparation for the brigade combat team which has now been withdrawn, to see if one of those facilities will match with the VA's use, which would be a win-win, I think, for the VA and the Army. It would certainly be a win for Liberty County and the city of Hinesville.

Senator ISAKSON. OK. Mr. Williams, I have been asked to ask you a question which you know the answer to. The new Health Care Center Facility Program—do you know what that is?

Mr. WILLIAMS. Pardon me, sir—

Senator ISAKSON. The new Health Care Facility Program? HCC? I am not an acronym guy. I apologize.

Mr. WILLIAMS. Yes, sir.

Senator ISAKSON. Tell me how that is going to work.

Mr. WILLIAMS. Well, the concept of a health care center is one of the components of our continuum of care that we provide to our veterans. If you look from our mobile clinics to an outreach clinic to a CBOC, we are able to increase the number of services we provide based upon the needs in those particular areas and based upon the resources that are available and are able to be provided.

The HCC kind of fits in between a medical center with inpatient beds and an independent clinic. It is a large outpatient operation with—it typically would have some special—a lot of specialty care, ambulatory surgery, high-end diagnostic capabilities. It typically will not have an inpatient bed section, and you will see some of these can be as large as from 300,000 to 500,000 square feet, depending on need. But again, what distinguishes it from others is that it is typically much larger than a CBOC and sometimes larger

than an independent clinic, but does not fit a full medical center profile. Typically, it doesn't have inpatient beds.

Senator ISAKSON. Well, let me thank all three of you for your testimony and for your service to our veterans. I will excuse you, and I am going to call our second panel up. Thank you very much.

Mr. WILLIAMS. Thank you, sir.

Senator ISAKSON. Mr. Williams, will you be able to stay until the second panel is complete? Thank you very much.

Our second panel is Mr. Tom Cook, the Assistant Commissioner of the Georgia Department of Veterans Services; Al Spears, the Quartermaster, Georgia Veterans of Foreign Wars; and Cort Nordeoff, the Southeast Georgia District Commander for Disabled American Veterans.

I think each one of you are prepared to give testimony, is that correct?

Mr. SPEARS. Yes, sir.

Senator ISAKSON. Yes. Good. I want to say to Mr. Tom Cook, I want you to deliver my best wishes to Pete Wheeler.

Mr. COOK. Certainly.

Senator ISAKSON. Georgia is proud of all of its veterans, but it is particularly proud—we have had the best Commissioner of Veterans Affairs any State could possibly have. He is older than dirt and he has been around, and his entire life he has dedicated to the veterans of Georgia. I just want you to personally extend him my thanks. I worked with him for years when I was in the Georgia Legislature, as I have worked with you, and I think you all do a fantastic, tremendous job. And please tell him I said so.

Mr. COOK. I certainly will. Yes, sir.

Senator ISAKSON. If it is all right with you, we will go with Mr. Cook first for his testimony, then to Mr. Nordeoff, and then Mr. Spears. Is that all right? Mr. Cook?

**STATEMENT OF TOM COOK, ASSISTANT COMMISSIONER,
FIELD OPERATIONS AND CLAIMS, GEORGIA DEPARTMENT
OF VETERANS SERVICES**

Mr. COOK. Thank you, Mr. Chairman and distinguished guests. It is an honor for me to be here, and thank you for inviting our Department to testify this afternoon. Commissioner Wheeler sends his personal regrets for not being able to be here due to his wife's serious health problems. It is my privilege to testify on his behalf; and Senator Isakson, Commissioner Wheeler wants you to know that he values your friendship and that he appreciates the interest of your Committee regarding veterans having top-notch and accessible health care available throughout all of Georgia.

As requested, we will limit our oral testimony to 5 minutes. We submitted our complete written testimony to you. We believe that our testimony reflects the feelings of the majority of veterans who are being treated in the VA clinics.

The feedback we received has been overwhelmingly positive and veterans are very pleased with the quality of care they are receiving. They speak highly of the screening done by the nurses. They state that the physicians are very dedicated to their jobs, very thorough in their examinations, that they listen carefully to what they say. Veterans seem very impressed with the increasing availability

of clinics and they are delighted that they no longer have to make the long drive to Atlanta, Dublin, Augusta, or Northern Florida for their routine appointments. They state that their appointments are scheduled in a timely manner and that they are seen promptly once they arrive. On a very positive note, we received many favorable comments regarding mental health treatment.

Co-location of State veterans service offices within the clinics facilitates one-stop shopping for our veterans health care and benefits concerns. We are presently co-located in the Athens, Savannah, St. Mary's, and Valdosta clinics and we would like for future plans to include space for our Department's representatives, as well, if possible. We currently have, as has been said, 15 clinics open in Georgia.

Within the past year, new clinics have opened in St. Mary's, Perry, and Stockbridge, and within the next few months we would hope they would be open in Newnan, certainly, then Brunswick as soon as possible. We eagerly await also the opening of clinics within the next months or so in Hinesville, Statesboro, Blairsville, Carrollton, and Milledgeville. Additionally, we understand that VA is planning to open a clinic in Waycross. These clinics are centrally and strategically located throughout Georgia and it is absolutely critical that all of them open as planned for our veterans to have the accessible outpatient health care they deserve.

We are disappointed that the contract for the Brunswick clinic had to be rebid due to complaints for contractors, and our understanding is that the estimates are that the clinic will open later this fall or down the road, as soon as we can. Although the delay is inconvenient for the veterans in the area, it does not seem to us to be excessive, at least not yet. We believe that VA is doing everything they can to open the clinic as soon as possible.

Although the focus of this hearing is on clinics, we believe that it is imperative that we emphasize the need for another VA hospital on the Southwest side of Atlanta. The Atlanta VA Hospital has too many patients and too few parking spaces. As Commissioner Wheeler would so eloquently state, the situation is much like trying to put a size 12 foot inside a size 6 shoe. We believe the answer to this problem is the Southwest Atlanta Medical Center, which is available on the Southwest side of Atlanta right now, and we understand that a request is at the VA Central Office. We request the support of your Committee, sir, in getting this important request approved by the VA as soon as possible. We have provided pictures of that hospital so you can see how nice it is and how much parking is available there. I have some extra copies with me, as well.

Thanks again for allowing us to testify. I will be happy to answer any questions you might have now or later, and may God bless the important service you provide and may God bless the United States of America. Thank you, sir.

[The prepared statement of Mr. Cook follows:]

PREPARED STATEMENT OF TOM COOK, ASSISTANT COMMISSIONER, FIELD OPERATIONS AND CLAIMS, GEORGIA DEPARTMENT OF VETERANS SERVICE

Mr. Chairman and Members of the Committee: Thank you for the opportunity to present the views of Commissioner Wheeler and Georgia Department of Veterans Service regarding veterans' perceptions of Community Based Outpatient Clinics in

Georgia. Commissioner Wheeler sends his personal regrets in not being able to testify due to circumstances surrounding his wife's health. He wants you to know that he values the friendship and support of Senator Isakson; and he appreciates the interest and concern of the Senate Committee on Veterans' Affairs regarding veterans having top notch and accessible health care available in the rural areas of Georgia, as well as in the more densely populated metropolitan areas of the state.

QUALITY OF CARE

Once we were notified of this hearing, we solicited comments from veterans and our department's field office representatives throughout Georgia to prepare for the hearing. Although time did not allow for investigation of complaints or confirmation of compliments, we believe that our testimony reflects the feelings of the majority of veterans who are being treated at our Community Based Outpatient Clinics (CBOC's).

The overwhelming response has been that veterans are extremely pleased with the outstanding quality of care they receive in the CBOC's. The reputation of the CBOC's among our veterans is exceptionally good. Veterans generally report being treated with courtesy and respect by a great staff. They speak highly of the screening done by the nurses. They state that the physicians are very dedicated to their jobs, that they are very thorough in their examinations, and that they listen carefully to what they say.

Veterans report that they believe the quality of care has improved at the Albany CBOC since the change from a private contract with Phoebe to a VA run clinic. We believe this is a significant lesson learned in providing top notch VA health care for CBOC's throughout the United States.

In some instances, veterans believe that personnel behind the sign in window are overly strict in the enforcement of "the line" to stand behind when another veteran is already at the window. This is particularly true when veterans come to the clinic for the first time. They may not know about "the line" and inadvertently cross over it. In some cases, veterans describe being made to feel like a "criminal" and being somewhat rudely "ordered" to get behind the line. Similarly, they state that in some cases the security guards are called out to ensure that they get behind "the line." Certainly, if a veteran is unruly, then calling security is appropriate. However, calling security seems premature for innocent violations of policy regarding "the line" when no disruptive behavior is involved.

We know that the Privacy Act and HIPPA requirements impose a high level of sensitivity regarding access to veterans' personal information. We fully support protecting the privacy and identity of our veterans. Perhaps some personnel are just being overly zealous in the enforcement of those requirements.

This is really the only area where we have received specific complaints regarding discourteous treatment. We do not intend to chastise the VA by raising this issue because we really believe that the overall courtesy and treatment of our veterans at the CBOC's is exceptionally good. We raise the issue simply because we suspect it is one that merits being given some attention across the VA health care system in clinics and in medical centers.

We think this could be addressed by having more prominent signs posted at the clinics regarding the policy and by including written notice of the policy in correspondence that goes to the veterans. We also think that training could be given to ensure that veterans who "cross the line" are treated in a courteous manner.

An additional observation along the same line of thought is that some veterans are frustrated by the protective glass window at some of the clinics. They report feeling like they are "in prison talking through a bullet proof glass." So, perhaps the tension between the need for adequate security and the need for a "warm" reception needs to be evaluated.

AVAILABILITY OF SERVICES

The feedback we have received from veterans indicates that they are very impressed with the steadily increasing availability and accessibility of outpatient treatment that is being offered through the CBOC's in Georgia. Many veterans are delighted that they no longer have to make the long drive to Atlanta, Dublin, Augusta, or Northern Florida for routine appointments in a VA Medical Center.

In most cases, veterans seem pleased that their appointments are scheduled in a timely manner. Once they arrive for their appointments, they report being seen promptly. In fact, some veterans report that they believe the CBOC's are much better organized and run than the VA medical centers.

However, due to the steadily increasing number of veterans in need of treatment throughout Georgia, some of the CBOC's (for example, Oakwood) have already

reached capacity and are no longer accepting new patients. Other clinics (for example, Columbus) are reported to be too small for the number of veterans served. Some clinics (for example, Valdosta) are reported to be in need of another Medical Team because of the size of the provider's panels.

These concerns highlight the need for VA to expand the size and staffing of existing clinics while opening additional clinics throughout Georgia. We are pleased with the progress that has been made thus far, but we are very cognizant of the fact that we cannot remain stagnant. We must continue to expand in order to provide the level of service to our veterans that they deserve.

We have received some complaints regarding the availability of specific treatment for women veterans. Some in Smyrna state that they are being referred to non-VA providers. Some women veterans have complained that pap smears and mammograms are not routinely provided in clinics.

We have received many favorable comments regarding mental health treatment. PTSD therapy has been overwhelming popular and has received many accolades. The only drawback is the length of time for the appointments due to the popularity.

We received a number of complaints regarding being able to "get through" or "leave messages" on the telephone systems. Similarly, some say that their messages are not answered and that their calls are not returned. Also, we have been informed that the number for the Perry Clinic is not listed anywhere. Consequently, our local office receives about 10 calls per day from veterans wanting the number for the clinic.

We are told that the Athens Clinic does not show up on GPS or MapQuest. Consequently, some veterans drive "all over creation" trying to find the clinic. Perhaps sending veterans a strip map would be helpful.

Co-location of State Veterans Service Offices within the CBOC's enhances the level of services available for the veterans and facilitates one stop shopping for their health care and benefit concerns and entitlements. We are presently co-located in the Athens, Savannah, St. Mary's and Valdosta clinics. We would like for future plans to include space for our department's representatives as well. We believe this is particularly important for Brunswick, Statesboro, Blairsville, Carrollton and Waycross. We also would like for consideration of co-location to be given during planning for expansion of any of the other clinics, especially Newnan and Stockbridge.

PLACEMENT OF CLINICS

We currently have 13 CBOC's and two additional Outpatient Clinics open in Georgia. We are aware of plans to open eight additional CBOC's within the next couple of years. Within the past year, new CBOC's have opened in St. Mary's, Perry and Stockbridge. VA will open the Newnan CBOC in September of this year.

We eagerly await the opening of CBOC's in Brunswick, Hinesville and Statesboro. VA has assured us that these clinics will open within the next year. The addition of these clinics will greatly increase accessibility for veterans in Southeast Georgia. Similarly, VA has assured us that CBOC's will open in Blairsville, Carrollton and Milledgeville, which will greatly improve accessibility in other areas of Georgia. We also understand that the CBOC in Carrollton will be a Mega, or Super, Clinic with up to 45K square feet of space and a number of specialty clinics, and that it will open within the next year.

Additionally, we understand that VA is planning to open a CBOC in Waycross. This location fills a great gap in distance for the veterans of Southeast Georgia. It is vital that a clinic open in Waycross as soon as possible.

These clinics are centrally and strategically located throughout Georgia. It is critical that all of them open as planned for our veterans to have the accessible outpatient health care they deserve.

We also emphasize that Georgia is the largest state east of the Mississippi River in land area. That fact, coupled with the steadily increasing veteran population in Georgia, highlights the need for additional clinics to be planned in the near future for other areas of the state. We suggest Canton, Dalton, Tifton, LaGrange, Griffin, and Hazlehurst for consideration.

REBIDDING OF BRUNSWICK CONTRACT

We are interested in getting a CBOC in Brunswick as soon as possible. In that regard, we are disappointed that the contract had to be rebid due to complaints from contractors. Our understanding is that the latest estimates project that the clinic will be open by late September or early October 2009. We have been told that the nursing staff has already been hired and that they are going through orientation training. We have been informed that the physicians are currently going through

the credentialing process, and that the remainder of the administrative staff position will be posted soon.

Although the delay is inconvenient for the veterans in the area, it does not seem to us to be excessive. We believe that VA is doing everything they can to open the clinic as soon as possible.

VA HOSPITAL ON WEST SIDE OF ATLANTA

Although the focus of this hearing is on CBOC's, we believe that it is imperative that we emphasize the need for another VA Medical Center on the West or Southwest side of Atlanta. The Atlanta VA Medical Center located in Decatur is faced with a continually growing number of patients and with a steadily increasing parking problem.

On a daily basis, veterans contend with long lines of vehicles extending to the highway waiting for their turn to park at the Atlanta VA Medical Center. Many veterans have to wait long periods of time before they are able to go to their appointment. Once they get inside the hospital, they are faced with additional delays due to the ever increasing number of patients being treated at the hospital.

Even if we could solve the parking problem today, the patient care problem would still exist. In fact, the number of patients will continue to increase due to the referrals that are made from the increasing number of CBOC's in the Atlanta area, as well as due to the treatment of increasing numbers of OIF/OEF veterans. The parking problem outside the hospital and the patient care problem inside the hospital combined are like trying to put a size twelve foot inside a size six shoe.

We need another VA hospital in Atlanta in order to provide timely and quality health care for the steadily increasing number of patients. We believe the answer to this problem is the Southwest Atlanta Medical Center, which is available on the southwest side of Atlanta right now. We are attaching information and photographs of this hospital for your perusal. This facility has more than adequate parking and is ready made for patient care. Once approved, VA will just need to negotiate the lease agreement and staff the hospital.

We understand that a request for another hospital is at the VA Central Office for a decision by Secretary Shinseki. We request the active support of the Senate Committee on Veterans' Affairs in getting this important request for an additional hospital in Atlanta approved by the VA as soon as possible.

Senator ISAKSON. Well, Tom, thank you very much. In your reference to Brunswick, I would say the numbers the VA committed, I think by mid-2010 in Brunswick, not the end of this year, but certainly within that reasonable period of time. I appreciate that very much.

Also, for all of you, your previously submitted printed testimony will, by unanimous consent, be published in the record, so it will be accepted from all of you.

Mr. Nordeoff?

**STATEMENT OF CORT NORDEOFF, SOUTHEAST GEORGIA
DISTRICT COMMANDER, DISABLED AMERICAN VETERANS**

Mr. NORDEOFF. Senator Isakson, I am honored and privileged to appear before you today. As the Southeast District Commander of the Disabled American Veterans, I appear here today on behalf of the State Commander of Georgia, Freddie Swint, and the 54,526 fellow disabled veterans in the Southeast District of Georgia.

Our National Office in Washington, DC, submitted a written statement for this hearing today. I ask that the statement be made a part of the record of this hearing.

Senator ISAKSON. Without objection.

Mr. NORDEOFF. At this time, sir, I would like to thank you and the Department of Veterans Affairs for all the positive steps that each of you have taken to provide for increased medical health for the veterans of the State of Georgia.

Due to the overwhelming numbers of Disabled American Veterans who reside in the districts, the need for a VA clinic is of utmost importance. For the State of Georgia, we have 133 community-based clinics, with only two on the East Coast. One clinic is located in the Northeast of the district, while the other one is located in the Southeast of the district.

While the Hinesville clinic would help serve the 15,425 disabled veterans who reside in the five surrounding counties, which could lessen the number of veterans who are currently being seen at the Savannah, Georgia, clinic, and that is not counting the 25,672 disabled veterans that are located in Chatham County. This could cut down on travel times for the veterans from 1–2 hours to approximately 30–40 minutes anywhere within the district.

Hinesville is the home of the Third Infantry Division, which is currently discharging soldiers on a daily basis, which adds to the percentage of 7,620 disabled veterans who reside in Liberty County and Hinesville. Also, with a clinic in Brunswick, we could help serve those 7,480 disabled veterans who reside in the three surrounding counties, which could lessen the number of veterans that are currently being seen in Kingsland, Georgia, clinic, which is not counting the 5,949 disabled veterans who reside in Camden County.

With the number of disabled veterans that are now in the district, the Disabled American Veterans just recently purchased a van for the Southeast District to provide transportation for disabled veterans so they will be able to make their appointments or any other medical treatment that the VA orders.

Thank you, sir. This concludes my testimony. On behalf of the Disabled American Veterans, I would be pleased to answer any questions from you or from the other members.

[The prepared statement of Mr. Nordeoff follows:]

PREPARED STATEMENT OF CORT NORDEOFF, SOUTHEAST GEORGIA DISTRICT
COMMANDER, DISABLED AMERICAN VETERANS

Senator Isakson and Members of the Committee: Thank you for inviting the Disabled American Veterans (DAV) to testify at this oversight hearing of the Committee to evaluate Georgia veterans' perceptions of Veterans' Affairs (VA) community-based outpatient clinics in terms of their quality of care, availability of services, and the placements of clinics in Georgia. Also the Committee specifically asked that I address the recent contract that was rebid for the community based outpatient clinic in Brunswick, GA. We value the opportunity to discuss our views. Rural health is an issue of significant importance to many DAV members in Georgia and veterans in general.

Approximately 3.2 million, or 41 percent, of veterans enrolled for VA health care throughout the country are classified by VA as rural or highly rural. Also, 44 percent of current active duty military servicemembers, who will be tomorrow's veterans, list rural communities as their homes of record. In the State of Georgia, rural Georgians have a proud tradition of military service dating all the way back to the American Revolution. VA estimates that 773,000 veterans live in Georgia, of which almost 23,000 are proud members of the DAV. In Georgia, VA meets veterans' health care needs with major medical centers in Atlanta, Augusta and Dublin. VA operates fourteen community-based outpatient clinics, in Albany; Athens; Columbus; Decatur; East Point; Lawrenceville; Macon; NE Georgia/Oakwood; Perry; Rome; Savannah; Smyrna; Stockbridge; and, Valdosta. VA plans to establish additional clinics based on unmet need. As a general rule, DAV is very pleased with the VA commitment to rural health care access in the State of Georgia. Nevertheless, research shows that when compared with their urban and suburban counterparts, veterans who live in rural settings in general have worse health-related quality-of-life scores; are poorer and have higher disease burdens; worse health outcomes; and are less

likely to have alternative health coverage. Such findings anticipate greater health care demands and thus greater health care costs from rural veteran populations.

Over the past several years, through authorizing legislation and additional appropriations, Congress has attempted to address unmet health care needs of veterans who make their homes in rural and remote areas. With nearly half of those currently serving in the military residing from rural, remote and frontier areas, access to VA health care and other veterans services for them is perhaps VA's biggest challenge. We recognize that rural health is a difficult national health care issue and is not isolated to VA's environment. We also appreciate that many service-connected disabled veterans living in rural areas face multiple challenges in accessing VA health care services, or even private services under VA contract or fee basis. Shortage of health care providers, long travel distances, weather conditions, geographical and financial barriers all negatively impact access to care and care coordination for many rural veterans, both the service-connected and nonservice-connected alike.

Section 212 of Public Law 109-461 authorized VA to establish the Veterans Health Administration (VHA) Office of Rural Health (ORH). We deeply appreciate the due diligence of this Committee and Congress as a whole in exerting strong support for rural veterans by enacting this public law.

As required by the Act, the function of the ORH is to coordinate policy efforts across VHA to promote improved health care for rural veterans; conduct, coordinate, promote and disseminate research related to issues affecting veterans living in rural areas; designate in each Veterans Integrated Service Network (VISN) rural consultants who are responsible for consulting on and coordinating the discharge of ORH programs and activities in their respective VISNs for veterans who reside in rural areas; and, to carry out other duties as directed by the Under Secretary for Health. In the Act, VA also was required to do an assessment of its fee-basis health care program for rural veterans to identify mechanisms for expanding the program and the feasibility and advisability of implementing such mechanisms. There were also a number of reports to Congress required including submission of a plan to improve access and quality of care for enrolled veterans in rural areas; measures for meeting the long term care and mental health needs of veterans residing in rural areas; and, a report on the status of identified and opened community-based outpatient clinics (CBOCs) and access points from the May 2004 decision document associated with the Capital Asset Realignment for Enhanced Services (CARES) plan. Finally, the Act required VA to conduct an extensive outreach program to identify and provide information about VA health care services to veterans of Operations Iraqi and Enduring Freedom (OIF/OEF) who live in rural communities for the purpose of enrolling these veterans into the VA health care system prior to the expiration of their statutory eligibility period (generally, five years following the date of military discharge or completion of deployments).

In addition to establishing the ORH, in 2008, VA created a 13-member VA Rural Health Advisory Committee to advise the Secretary on issues affecting rural veterans. This panel includes physicians from rural areas, disabled veterans, and experts from government, academia and the non-profit sectors. We applaud former VA Secretary Peake for having responded to our recommendation in the Fiscal Year (FY) 2009 *Independent Budget (IB)* to use VA's authority to form such a committee. We hold high expectations that the Rural Veterans Advisory Committee will be a strong voice of support for many of the ideas we have expressed in previous testimony before Congress, and joined by our colleagues from AMVETS, Paralyzed Veterans of America, and the Veterans of Foreign Wars of the United States, in the *IB*.

We are pleased and would like to congratulate VA on its progress to date in establishing the necessary framework to begin to improve services for rural veterans. It appears that ORH is reaching across the Department to coordinate and support programs aimed at increasing access for veterans in rural and highly rural communities. We note, however, that the ORH has an ambitious agenda but only a minimal staff and limited resources. The ORH is still a relatively new function within VA Central Office and it is only at the threshold of tangible effectiveness, with many challenges remaining. Given the lofty goals of Congress for rural health improvements, we are concerned about the organizational placement of ORH within the VHA Office of Policy and Planning rather than being closer to the operational arm of the VA system. Having to traverse the multiple layers of VHA's bureaucratic structure could frustrate, delay or even prevent initiatives established by this office. We believe rural veterans' interests would be better served if the ORH were elevated to a more appropriate management level in VA Central Office, with staff augmentation commensurate with its stated goals and plans.

We understand that VA has developed a number of strategies to improve access to health care services for veterans living in rural and remote areas. To begin, VA

appointed rural care designees in all its VISNs to serve as points of contact in liaison with ORH. While we appreciate that VHA designated the liaison positions within the VISNs, we expressed concern that they serve these purposes only on a part-time basis. We are pleased that VA is conducting a pilot program in eight VISNs to determine if the rural coordinator function should be a part-time or a full-time position.

VA reported that its approach to improving services in rural areas includes leveraging existing resources in communities nationwide to raise VA's presence through outreach clinics, fee-basis, contracting, and use of mobile clinics. Additionally, VA testified it is actively addressing the shortage of health care providers through recruitment and retention efforts; and harnessing tele-health and other technologies to reduce barriers to care. Also, in September 2008, VA announced plans to establish new rural outreach clinics in Houston County, Georgia, Juneau County, Alaska, and Wasco County, Oregon. VA plans to open six additional outreach clinics by August 2009 in: Winnemucca, NV; Yreka, CA; Utuado, PR; LaGrange, TX; Montezuma Creek, UT; and Manistique, MI.

VA also reported that it has conducted other forms of outreach and developed relationships with the Department of Health and Human Services (HHS) (including the Office of Rural Health Policy and the Indian Health Service), and other agencies and academic institutions committed to serving rural areas to further assess and develop potential strategic partnerships. Likewise, VA testified it is working to address the needs of veterans from OIF/OEF by coordinating services with the HHS' Health Resources and Services Administration community health centers, and that these initiatives include a training partnership, technical assistance to community health centers and a seamless referral process from community health centers to VA sources of specialized care.

In August 2008, VA announced the establishment of three "Rural Health Resource Centers" for the purpose of improving understanding of rural veterans' health issues; identifying their disparities in health care; formulating practices or programs to enhance the delivery of care; and, developing special practices and products for implementation VA system-wide. According to VA, the Rural Health Resource Centers will serve as satellite offices of ORH. The centers are sited in VA medical centers in White River Junction, Vermont; Iowa City, Iowa; and, Salt Lake City, Utah.

Given that 44 percent of newly returning veterans from OEF/OIF live in rural areas, the *IB* veterans service organizations believe that these veterans, too, should have access to specialized services offered by VA's Readjustment Counseling Service, through its Vet Centers. In that regard, we are pleased to acknowledge that VA is rolling out a fleet of 50 mobile Vet Centers this year to provide access to returning veterans and outreach at demobilization sites on military bases, and at National Guard and Reserve units nationally.

The issue of rural health is an extremely complex one and we agree with VA that there is not a "one-size-fits-all" solution to this problem. To make real improvements in access to the quality and coordination of care for rural veterans, we believe that Congress must provide continued oversight, and VA must be given sufficient resources to meet its many missions, including improvements in rural health care.

In regard to funding for rural health, in 2008 VA allocated almost \$22 million to VISNs to improve services for rural veterans. This funding is part of a two-year program and would focus on projects including new technology, recruitment and retention, and close cooperation with other organizations at the Federal, state and local levels. These funds were used to sustain current programs, establish pilot programs and establish new outpatient clinics. VA distributed resources according to the fraction of enrolled veterans living in rural areas within each VISN. It is DAV's understanding that VISNs with less than three percent of their patients in rural areas, received \$250,000, those with between three and six percent received \$1 million, and those with six percent or more received \$1.5 million.

The ORH has testified VA allocated another \$24 million to sustain these programs and projects into 2009, including the Rural Health Resource Centers, mobile clinics, outreach clinics, VISN rural consultants, mental health and long-term care projects, and rural home-based primary care, and has convened a workgroup of VISN and Central Office program offices to plan for the allocation of the remaining funds. In February 2009, ORH distributed guidance to VISNs and program offices concerning allocation of the remaining funds to enhance rural health care programs.

Concurrently, Public Law 110-329, the Consolidated Security, Disaster Assistance, and Continuing Appropriations Act, 2009, approved on September 30, 2008, included \$250 million for VA to establish and implement a new rural health outreach and delivery initiative. Congress intended these funds to build upon the work of the ORH by enabling VA to expand initiatives such as telemedicine and mobile

clinics, and to open new clinics in underserved and rural areas. Notably, the bill also included \$200 million for additional fee-basis services.

Health workforce shortages and recruitment and retention of health care personnel, are also a key challenge to rural veterans' access to VA care and to the quality of that care. The Institute of Medicine of the National Academy of Sciences report "Quality through Collaboration: The Future of Rural Health" (2004) recommended that the Federal Government initiate a renewed, vigorous, and comprehensive effort to enhance the supply of health care professionals working in rural areas. To this end, VA's deep and long-term commitment to health professions education seems to be an appropriate foundation for improving these situations in rural VA facilities as well as in the private sector. VA's unique relationships with health professions schools should be put to work in aiding rural VA facilities with their human resources needs, and in particular for physicians, nurses, technicians, technologists and other direct providers of care. The VHA Office of Academic Affiliations, in conjunction with ORH, should develop a specific initiative aimed at taking advantage of VA's affiliations to meet clinical staffing needs in rural VA locations. While VA maintains it is moving in this general direction with its pilot program in a traveling nurse corps; VA's pilot program in establishing a "nursing academy," initially in four sites and expanding eventually to twelve; its well-founded Education Debt Reduction Program and Employee Incentive Scholarship Program; and, its reformed physician pay system as authorized by Public Law 108-445, none of these programs was established as a rural health initiative, so it is difficult for DAV to envision how they would lend themselves to specifically solving VA's rural human resources problems. We do not see them as specific initiatives aimed at taking advantage of VA's affiliations to meet clinical staffing needs in rural VA locations.

The DAV has a national resolution from its membership, Resolution No. 247, reaffirmed at our National Convention in Denver, CO, August 22-25, 2009, fully supporting the rights of rural veterans to be served by VA, but insisting that Congress provide sufficient resources for VA to improve health care services for veterans living in rural and remote areas. We thank VA and this Committee for supporting specific-purpose funding for rural care without jeopardizing other VA health care programs, consistent with our adopted resolution. Furthermore, we appreciate the Committee's interest in conducting this oversight hearing to learn more from VA about the local situation here in Georgia. Such information serves everyone's interest in ascertaining how rural veterans receive care at VA's expense that otherwise might not have received care were it not for the new resources made available for rural veterans, as well as gathering data on how their health outcomes have been affected as a measure of the quality of care.

VA's previous studies of rural needs, identified the need for 156 priority CBOCs and a number of other new sites of care nationwide, recently including some here in Georgia. A March 30, 2007, report submitted to Congress indicates 12 CBOCs had been opened, 12 were targeted for opening in FY 2007, and five would open in FY 2008. In June 2008, VA announced plans to activate 44 additional CBOCs in 21 states during FY 2009. As of the end of the second quarter of FY 2009, VA reported 768 clinics in operation, 392 of which are in urban settings, 337 in rural areas, and 38 in highly rural locations. VA directly staffs 540 clinics, and the remainder of these CBOCs are managed by contractors. Of the CBOCs VA operates, 353 are doing real-time video conferencing (predominantly tele-mental health), while 130 CBOCs are transmitting tele-retinal imaging for evaluation by specialists in VA medical centers. Services such as these greatly enhance patient care, extend specialties into rural and highly rural locations, and drastically cut down on long-distance travel by veterans. In addition, VA is expanding its capability to serve rural veterans by establishing rural outreach clinics. Currently, 12 VA outreach clinics are operational, and more are planned. These are major investments by VA, and we appreciate both VA and Congress for supporting this level of extension of VA services into more and more communities.

While we applaud the VHA for improving veterans' access to quality care and its intention to spread primary and limited specialty care access for veterans to more areas, enabling additional veterans access to a convenient VA primary care resource, DAV urges that the business plan guiding these decisions generally first emphasize the option of VA-operated and staffed facilities. When geographic or financial conditions warrant (e.g., highly rural, scarceness, remoteness, etc.), we do not oppose the award of contracts for CBOC operations or leased facilities, but we do not support the general notion that VA should rely heavily or primarily on contract CBOC providers to provide care to rural veterans.

We understand and appreciate those advocates on this Committee and in Congress in general who have been successful in enacting authority for VA to increase health care contracting in rural areas through a new multi-VISN pilot program en-

acted in Public Law 110–387. However, in light of the escalating costs of health care in the private sector, to its credit, VA has done a remarkable job of holding down costs by effectively managing in-house health programs and services for veterans. While some service-connected and nonservice-connected veterans might seek care in the private sector as a matter of personal convenience, doing so may well cause them to lose the safeguards built into the VA system by its patient safety program, prevention measures, evidence-based treatments, national formulary, electronic health record, and bar code medication administration (BCMA), among other protections. These unique VA features culminate in the highest quality care available, public or private. Loss of these safeguards, ones that are generally not available in private sector systems or among individual practitioners or group practices (especially in rural areas), would equate to diminished oversight and coordination of care, lack of continuity of care, and ultimately may result in lower quality of care for those who need quality the most.

For these reasons, we urge Congress and VA's ORH to closely monitor and oversee the development of the new rural pilot demonstration project from Public Law 110–387, especially to protect against any erosion or diminution of VA's specialized medical programs, and to ensure participating rural and highly rural veterans receive health care quality that is comparable to that available within the VA's health care system. We are pleased that the ORH reported it is coordinating with the Office of Mental Health Services, to implement this pilot program. We ask VA, in implementing this demonstration project, to develop a series of tailored programs to provide VA-coordinated rural care (or VA-coordinated care through local, state or other Federal agencies, as VA has previously claimed it would be doing) in the selected group of rural VISNs, and to provide reports to the Committees on Veterans' Affairs, of the results of those efforts, including relative costs, quality, satisfaction, degree of access improvements and other appropriate variables, compared to similar measurements of a like group of rural veterans who remain in VA health care. To the greatest extent practicable, VA should coordinate these demonstrations and pilots with interested health professions academic affiliates. We recommend the principles outlined in the Contract Care Coordination section of the FY 2010 *IB* be used to guide VA's approaches in this demonstration, and that it be closely monitored by VA's Rural Veterans Advisory Committee, with results reported regularly to Congress.

We also recommend that VA be required to provide more thorough reporting to this Committee, to enable meaningful oversight of the use of the funds provided, and the implementation of the authorizing legislation that serves as a foundation for this work. We urge the Committee to consider legislation strengthening recurring reporting on VA rural health as a general matter. We are concerned that funds Congress provided to VA to address shortages of access in rural areas will simply be dropped into the VA "Veterans Equitable Resource Allocation" (VERA) system, absent means of measuring whether these new funds will be obligated in furtherance of Congress's intent—to enhance care for rural and highly rural veterans, with an emphasis on outreach to the newest generation of war veterans who served in the National Guard, and hail from rural areas, including our State. Reports to Congress should include standardized and meaningful measures of how VA rural health care capacity or "virtual capacity" has changed; VA should provide recorded workload changes on a quarterly or semi-annual basis, and disclose other trends on whether the rural health care initiatives and funds allocated for them are achieving their designed purposes.

In closing, DAV believes that VA is working in good faith to address its shortcomings in rural areas, but VA clearly still faces major challenges and hurdles. In the long term, its methods and plans may offer rural and highly rural veterans better opportunities to obtain quality care to meet their specialized health care needs. However, we caution about the trend toward privatization, vouchering and contracting out VA health care for rural veterans on a broad scale. As VA's ORH develops its policies and initiatives, DAV cannot stress enough the importance of communication and collaboration between this office, other VA program offices, field facilities, and other Federal, state and local organizations, to reach out and provide VA benefits and services to veterans residing in rural and highly rural areas. As noted above, we are concerned that the current staffing level assigned to ORH will be insufficient to effectively carry out its mission. Moreover, DAV believes ORH's position in VHA's organizational structure may hamper its ability to properly implement, guide and oversee VA's rural health care initiative. Also, Congress should monitor VA's funding allocation to ensure that rural health needs do not interfere with other VA medical obligations. Finally, we are hopeful that with continued oversight from this Committee and, with these principles in mind; rural veterans will be better served by VA in the future.

Senator Isakson, your invitation letter asked specific questions regarding the local situation in rural Georgia, and in particular about the status of the Brunswick community-based outpatient clinic, that I would be pleased to discuss in my oral remarks.

This concludes my formal statement submitted on behalf of DAV. I would be happy to address questions from you or other Members of the Committee.

Senator ISAKSON. Thank you very much, Mr. Nordeoff.
Mr. Spears?

STATEMENT OF ALBERT R. SPEARS, ADJUTANT/QUARTERMASTER, DEPARTMENT OF GEORGIA, VETERANS OF FOREIGN WARS OF THE UNITED STATES

Mr. SPEARS. Good afternoon, Senator and members of your staff. First, if I can, I haven't heard anyone say anything, but I would like to offer the condolences, prayers, and best wishes for the family of Senator Kennedy, the lion of the Senate. Senator Kennedy helped many on both sides of the aisle in his many years and he was himself a veteran.

Thank you for inviting the Veterans of Foreign Wars of the United States to share its views with you on this important topic. As you know, I am Albert Spears, the State Adjutant/Quartermaster of the Department of Georgia Veterans of Foreign Wars.

The topic of the Community-Based Outpatient Clinics, CBOCs, as you recognized, is both important and timely, but the topic is not a stand-alone topic. There are significant issues that affect the CBOCs and quality of care that they provide, the range of services that they offer, and the placement of those clinics. The idea is to place and staff CBOCs with Department of Veterans Affairs employees in a reasonable proximity of the homes of the veterans to be served. The CBOCs and the system administering them must not only be located near the population to be served, but also must provide the range of services required not just today, but tomorrow and into the future.

I would like to sit here and tell you that everything is great with the CBOCs. I want to tell you that the quality of care is world class, the range of services is direct and as it should be, and that a CBOC is currently located exactly across Georgia, where it should be, but I cannot.

Currently in Georgia, our CBOCs are operated by VAMCs in South Carolina, Florida, Alabama, as well as Georgia, and we have people from Georgia going into Tennessee. We need some sort of better coordination and may even need some sort of CBOC command in Georgia. The point will not be lost on you that these represent not only several different hospitals and medical centers, but several different Veterans Integrated Service Networks, or VISNs. Consistency of service is not a strong point.

The CBOCs must meet the needs not only of the many elderly veterans from World War II, Korea, and Vietnam, they must increasingly meet the needs of the younger veteran of the current conflicts of the First Gulf War, Operation Enduring Freedom, and Operation Iraqi Freedom. Each must deal with the medical issues of age-related diabetes, for example, and those of Traumatic Brain Injury and traumatic amputation on the battlefield.

We must also not ignore the needs of our female veterans. While each of us realizes the current makeup of the all-volunteer mili-

tary, we must acknowledge and understand that women are veterans, too. It is not just a slogan or a campaign speech. Women have been a vital part of the Armed Forces since the days when Molly Pitcher kept the guns firing at the Battle of Monmouth to today's females being awarded the Silver Star for gallantry in action.

And to our enduring discredit, they have not always been treated with honor, respect, and the dignity which they deserve. Yet we have women veterans having their civilian medical insurance being charged by the VA when they are being treated at the VA for service-connected disabilities. This continues still.

Regardless of the value of the CBOCs throughout Georgia, a female veteran cannot obtain routine care that is required for her as expected by her age group, and female veterans represent about 25 percent of the veterans population needing care in Georgia. Our female veterans express that the medical health care providers within the VA system and contracted health care providers frequently do not take them seriously. The providers do not seem concerned about our female warriors' medical problems and their association of various conditions from the combat environment.

The VA simply must also deal with the issue of child care. Pap smears, mammograms, pre- and post-menopausal care, and sexual trauma care are practically nonexistent in the system today, especially in the CBOC. This does not even consider the other needs and other gynecological needs such as fertility counseling that may be necessary. Since we have decided to make so many of these young women into almost professional athletes by the various services' physical and strength training, many of our female warriors have not had normal menstrual cycles in years.

There are various programs established for and targeting female veterans, but most require travel to centers and programs that simply cannot be considered reasonable, especially for our younger female veterans that are frequently single parents.

One point that I pray is not missed and does not fall on deaf ears is that a female veteran that files a claim for service connection as a victim of military sexual trauma while in the service, whether it was last week or 60 years ago, should be considered presumptive if she is suffering the mental effects of that trauma. She should not be further traumatized and revictimized by having to prove service connection when every cog in the system in which she was operating told her to take it and forget it happened when it happened.

Remember that the movie "The General's Daughter" was, in essence, a true story of rape in the military and that was what we call the modern military. We must all remember the scandals over the years of the drill sergeants and their trainees, the scandals of the rapes, and the institutional cover-ups at various service academies. Presumption of service connection is a must-do. It cannot wait and it must be done now, by legislation, if necessary.

Again, I realize that the CBOC cannot do everything, but we are not serving any of our Post Traumatic Stress victims properly at the CBOC, nor are we doing a very good job at the VAMCs. The staff of each is trying hard, and I want to stress this. The staff of each is trying hard to accommodate the need, but it simply is not being met. The suicide rate demonstrates that fact.

Our female warriors should be placed in PTSD group counseling sessions with other female veterans. This can be as simple as mental health visiting and establishing a group within the women's clinic each month.

For the topic at hand, the Brunswick CBOC, I found no one that discussed any dissatisfaction with that facility except the time that it is taking to get it online.

With noted exceptions regarding female veterans, the CBOCs are providing outstanding services and an adequate range of services. Many clinics have waiting times for appointments and procedures that are excessive.

We must also remember that with the reduction of medical staffs in rural America, much of the previous access to medical care that may have been available in an area has been diminished drastically. I have noticed as I have driven through the State of Georgia numerous offices of health care providers that have been closed, as well as clinics and hospitals. There may be an opportunity to lease or purchase some of these facilities for CBOCs in needed areas, as an example, in McRae in Telfair County. That hospital was closed within the last year. Such efforts may be beneficial to attract medical-related businesses to the area, such as pharmacies and drug stores.

Prime irritants within the CBOCs, and the entire VA health care system are—and I am just about finished, if you would bear with me—telephone numbers. There never seems to be a direct telephone number to anybody. I can call your office direct, and even if you are not on the floor, I can talk to you. Unfortunately though, I can't call Larry Biro, by way of a direct line. I have got to go through three switchboards and two patient advocates in order to get there.

Appointment wait times—some CBOCs have a very short waiting time, such as Stockbridge, and others have a significantly longer waiting time, such as Smyrna. Endless “round-robin” telephone systems—no one minds a truly responsive telephone menu system, but too many of them are endless loops within the VA system.

In closing, I must reiterate the treatment of our female veterans. Our women warriors served this Nation in the true spirit of Palace Athena and they need to receive the health care treatment to which they are entitled. Only one clinic at the VAMC Atlanta treats these great warriors. The purchase of the Southwest Atlanta Medical Center is available now. Purchase of that facility and conversion to a VA medical center could facilitate the expansion of health care services across the board so desperately needed now by freeing up space in Decatur or making it available at Southwest Atlanta Medical.

Thank you for inviting me here today, and I welcome any questions.

[The prepared statement of Mr. Spears follows:]

PREPARED STATEMENT OF ALBERT R. SPEARS, STATE ADJUTANT/QUARTERMASTER,
DEPARTMENT OF GEORGIA VETERANS OF FOREIGN WARS OF THE UNITED STATES

Good Afternoon, Senator Isakson and members of this Field Hearing of the Senate Veterans' Affairs Committee. Thank you for inviting the Veterans of Foreign Wars of the United States to share its views with you on this important topic. As you will

recall, I am Albert Spears, the State Adjutant/Quartermaster of the Department of Georgia Veterans of Foreign Wars of the U.S.

The topic of Community-Based Outpatient Clinics (CBOCs) as you recognize is both important and timely and I will address it directly—its strengths and its shortcomings. But the topic is not a stand-alone topic. There are significant issues that affect the CBOCs and the quality of care that they provide, the range of services that they offer, and the placement of those clinics.

The ideal is to place and staff with Department of Veterans Affairs employees, CBOCs in a reasonable proximity of the homes of the veterans to be served. The CBOCs and the system administering them not only must be located near the population to be served but also must provide the range of services required not just today, but tomorrow and in to the future.

I would like to sit here and tell you that everything is great with the CBOCs. I want to tell you that the quality of care is world class, that the range of services is direct and as it should be, and that a CBOC is currently located exactly where it should be. Alas, I cannot.

Currently in Georgia, our CBOCs are operated by VAMCs in South Carolina, Florida, Alabama, Tennessee, as well as Georgia. We need some sort of better coordination and may even need a “CBOC Command” in Georgia. The point will not be lost on you that these represent not only several different hospitals/medical centers but also several different Veterans Integrated Service Networks (VISN). Consistency of services is not a strong point.

The CBOCs must meet the needs not only of the many elderly veterans of World War II, Korea, and Vietnam; they must also meet increasingly the needs of the younger veteran of the current conflicts of the first Gulf War, Operation Enduring Freedom, and Operation Iraqi Freedom. Each must deal with the medical issues of age related diabetes (as an example) and those of Traumatic Brain Injury and traumatic amputation from the battlefield. We also must not ignore the needs of our female veterans. While each of us realizes the current make-up of the All Volunteer Military, we must acknowledge and understand that women are veterans too!

Women are veterans too is not just a slogan or campaign speech. Women have been a vital part of the Armed Forces since the days of Molly Pitcher keeping the field guns firing at the Battle of Monmouth to today's females being awarded the Silver Star for gallantry in action. And to our enduring discredit, they have not always been treated with honor, respect, and dignity that they deserve. Yet, we have women veterans having their civilian medical insurance being charged by the VA when treated at the VA for established service-connected disabilities.

Regardless of the value of the CBOCs throughout Georgia, a female veteran cannot obtain routine care that is required for her as expected by her age group and female veterans represent about 25 percent of the veteran population needing care in Georgia.

Our female veterans express that the medical healthcare providers within the VA System and contracted health care providers do not take them seriously. The providers do not seem as concerned about our female warriors' medical problems and the association of various conditions with combat and the combat environment.

The VA simply must deal with the issue of child-care. The Department of Defense is working toward providing child-care while warriors are receiving medical treatment; the VA has to consider this as well. We have so many patients that need treatment—not all of whom are female nor even young—that are single parents and have no place to leave a child when going to the VA for treatment. This certainly requires a review.

Pap smears, mammograms, pre/post menopausal care, sexual trauma care are practically non-existent in the system today. This does not even begin to consider other needs and other gynecological needs such as fertility counseling that may be necessary after we have made so many young women almost professional athletes by the various services' physical and strength training that many of our female warriors have not had normal menstrual cycles in years. There are several programs established for and targeting our female veterans but most require travel to centers and programs that simply cannot be considered reasonable especially for our younger female veterans that are frequently single parents.

One point that I pray is not missed and does not fall of deaf ears—a female veteran that files a claim for service connection as a victim of sexual trauma while in the service whether or not it was last week or 60 years ago should be considered “presumptive” when she is suffering the mental effects of that trauma. She should not be further traumatized and re-victimized by having to prove service connection that every cog in the system told her she should just “. . . take it and forget it happened . . .” when it happened. Remember that the movie “The General's Daughter” was in essence a true story of rape in the military and it was what we

call the modern military. We all remember the scandals over the various years of the drill sergeants and their trainees and the scandals of the rapes and institutional cover-ups at the various service academies. Presumption of service connection is a must do; it cannot wait and must be done now, by legislation if necessary.

Again, I realize that the CBOC cannot do everything but we are not serving any of our real Post Traumatic Stress victims properly at the CBOC nor are we doing a very good job at the Veterans Administration Medical Centers (VAMC). The staff of each is trying hard to accommodate the need but it is not being met. The suicide rate simply demonstrates that fact. Our female warriors should be placed in PTSD group counseling sessions with other female veterans. This can be as simple as mental health visiting and establishing a "group" in the Women's Clinic once each month.

For the topic at hand, the Brunswick CBOC—I found no one that discussed treatment specifically at that clinic either good or bad. As I alluded to earlier in my testimony, the VFW prefers that all clinics be staffed with professionals employed by the Department of Veterans Affairs. We realize that may not always be possible and some may have to be staffed by contract. The difficulty with contracting is that regardless of the requirements that are or should be built into the contract as performance standards, the perception is that contract personnel are less receptive to the needs of veterans especially elderly ones. It seems to get lost to the contractor that the old man who is moving so slowly on the walker, has hearing aids in both ears, wears coke bottle thick glasses, and talks too loud in the waiting room was the same young man who charged a machine gun nest 65 years ago on an island in the Pacific saving the lives of countless Marines.

With the noted exceptions regarding female veterans, the CBOCs are providing outstanding services and an adequate range of services. At many clinics the appointment waiting times (and procedures) are excessive.

We must also remember that with the reduction of medical staffs in rural America, much of the previous access to medical care that may have been available in an area has been diminished drastically. I have noticed as I have driven the State of Georgia, numerous offices of healthcare providers that have closed as well as clinics and county hospitals. There may be an opportunity to lease or purchase some of these facilities for CBOCs in needed areas. Such efforts might also be beneficial to attracting medical related businesses to the area as well such as pharmacies and drug stores.

Prime irritants regarding the CBOCs but also apply to the entire VA Health Care System are:

a. Telephone Numbers—there never seems to be a published direct telephone number to a clinic or a number at which a patient can talk to a human being. I can (and do) pick up the telephone and call your office, the Chief of Staff of the Army's Office, the Secretary of Veterans Affairs Office, but I cannot call the Office of the Director of VAMC-Atlanta's Office or even the direct line to the Stockbridge CBOC.

b. Appointment Wait Times—While some CBOCs have a very short wait time, others have significant wait times even when the appointment is needed solely for a referral for a serious condition.

c. Endless "round robin" telephone systems—No one truly minds telephone menu systems that sort and a route to ultimate solutions. Too many of those in the VA Health Care System result in having to leave a message to await a call back at some date in the future. Too frequently that call never comes. Appointments, prescription refills, specialty referral requests, and even calls to the patient advocate are too frequently on such systems.

In closing, I must return to treatment of our female veterans. Our women warriors served this Nation in the true spirit of Pallas Athena and they needed to receive the healthcare treatment they are entitled. Only one clinic at the VAMC-Atlanta treats these great warriors. The purchase of the Southwest Atlanta Medical Center in Atlanta is available now. Purchase of that facility and conversion to a VA Medical Center could facilitate the expansion of healthcare services so desperately required now by freeing space at Decatur or making it available at Southwest Atlanta Medical.

Thank you for inviting me here today.

Senator ISAKSON. Well, thank you, Mr. Spears.

First of all, Mr. Nordeoff, if I made my notes correctly on your testimony, there are 54,526 disabled veterans in Southeastern Georgia?

Mr. NORDEOFF. Yes, sir.

Senator ISAKSON. And you made note of the extensive burden on the Savannah facility now. So, I want to ask you this question. With the opening of a Hinesville facility in 2011 and the Brunswick facility in 2010, will that—do you think that meets the needs of those 54,000 and reduce the extended waiting time periods?

Mr. NORDEOFF. Yes, sir, I believe it is going to help a lot. Because right now, that would end up giving Hinesville and the local area 15,000 people going there. Savannah would have 25,000. So it would influx a whole bunch of—

Senator ISAKSON. Savannah would have 25,000 after the opening of Hinesville?

Mr. NORDEOFF. Yes, sir.

Senator ISAKSON. OK.

Mr. NORDEOFF. Yes, sir. They have got 25,672 as we speak.

Senator ISAKSON. OK.

Mr. NORDEOFF. Plus there are 15,000 from the surrounding areas in Hinesville, Georgia.

Senator ISAKSON. Some of those 25,000 that are using Savannah now would probably transition to Hinesville, would they not?

Mr. NORDEOFF. Yes, sir, I would imagine.

Senator ISAKSON. So, it would relieve some of Savannah's pressure by opening Hinesville.

Mr. NORDEOFF. Yes, sir. Yes, sir.

Senator ISAKSON. What about the positive effect of Brunswick? Have you quantified that?

Mr. NORDEOFF. Yes, sir. Yes, sir. Brunswick, just where Kingsland is, sir, Camden County, they are doing 5,949 veterans as we speak. Now, from the three surrounding counties, there are 7,408 disabled veterans. So, with a Brunswick clinic and the three surrounding areas, they would end up taking 7,480 off of Kingsland, where Kingsland is running 5,949, sir.

Senator ISAKSON. So the timely opening of Brunswick and Hinesville will make a dramatic improvement in the accessibility for veterans in this region?

Mr. NORDEOFF. Yes, sir. The Brunswick clinic wouldn't have to be as big as the Hinesville clinic. The Hinesville clinic has got to be something to maintain, you know, for PTSD and everything like that.

Senator ISAKSON. Well, let the record reflect that is precisely why we are having this hearing today, so that is exactly the intent we plan for.

Mr. SPEARS, on your statement with regard to the presumption of service connection in terms of sexual harassment or abuse, you are referring that presumption to the VA's responsibility to treat, not to the conviction of a perpetrator, is that correct?

Mr. SPEARS. Yes, sir. I am not speaking of any prosecution or anything. I am talking about if a psychiatrist has found that this person has, indeed, suffered that trauma and so forth, it should be considered service-connected, period. I am not talking about prosecution or anything of that nature.

Senator ISAKSON. I just want to make sure the record was correct on that.

Mr. SPEARS. Yes, sir. Absolutely.

Senator ISAKSON. Also, I do appreciate your emphasis on women. As you know, in the earlier panel, I made reference to the trauma which a number of women are going through in our Warrior Transition Centers because of the uniqueness of some of the injuries that they are affected with, orthopedically and other ways, so I appreciate your raising that again.

I will say, in my interaction with the VA hospitals and facilities, I think that is of note to them now. Not that they were not looking at it before, but I think the intensity of the number of unique health-related circumstances is causing a bigger focus on our women veterans. We appreciate their service and I appreciate your bringing that up.

Mr. SPEARS. Yes, sir. Thank you. I also noted that after I filed my testimony with your office and with the Senate Veterans' Affairs Committee, that Secretary Shinseki has come forward and modified some of the requirements on PTSD.

Senator ISAKSON. Thank you for that. I have one other question for you, if I can.

Mr. SPEARS. Yes, sir.

Senator ISAKSON. From your discussions with veterans, have you been able to see a difference in patient satisfaction between VA-staffed clinics and contract clinics?

Mr. SPEARS. Yes, sir. Quite honestly, and there is a portion of it in my prepared remarks. The veteran himself—and whether it is just a perception, but as you know, when you are in there, perception is reality—that they are better treated by VA employees. Many times it is because the VA employees themselves are veterans, as Mr. Biro mentioned. He is a veteran. They feel that they are better treated. You don't really get across, necessarily, to a contractor that the old guy wearing two hearing aids and walking on a walker and talking too loud in the waiting room is a guy who 65 years ago charged a machine gun nest and saved countless Marines.

Senator ISAKSON. My comment on that would be, I think that is an appropriate issue to raise; and I think as the VA contracts for services, that recognition should be there so that sensitivity becomes a part of the contract. I don't think the care of the physicians itself is substandard, but I think maybe the lack of sensitivity to the veteran may not be there simply because, unfortunately, it is like the U.S. Senate. There are only 27 of us, I think, that served, or 30, something like that, and there is a disconnect in some cases. I think possibly the VA could note in their contracts with the providers to recognize who these men and women are and where they have come from and what they have done to sacrifice for our country.

Tom, did VA contact your office when it was apparent that there would be delays in opening the Brunswick clinic? And how would you rate the communication from the VA to your Department in Georgia?

Mr. COOK. My hearing is—did you ask, did VA contact us—

Senator ISAKSON. Were you in contact when the delays of Brunswick were encountered with the first re-do of the first contract to go to a second offering? Were you made aware that was happening so you could communicate it?

Mr. COOK. We were not made—to my knowledge, we were not made aware, no, sir, not until the—when the issue was raised by your office in conjunction with this hearing. That could be as much part of us as them. But I do not believe that as far as a delay in the contract or the rebidding process, that we were made aware of it until the call came to prepare for this hearing. We started asking questions at that point, as far as what was going on with it and what the delay involved.

Senator ISAKSON. Well, the reason I asked the question is, I understand the tremendous—I understand Mr. Spears' comments about how many computers you have to talk to on the telephone before you get to a person. I deal with that frustration myself. Communication is a very important thing, and a lot of frustration with services is more out of frustration with the lack of information and communication than it is the actual service. So I think there is a good lesson. You know that in representing those you represent—either VFW, American Legion, Disabled Veterans, whatever.

I think it should be well noted, one of the best things the Georgia Department of Veterans Services has going for it is Pete Wheeler—a one-man communications center—who makes sure the veterans know that he knows what is on their minds. So your comments there are well noted.

Mr. COOK. The other part that I believe you asked, in terms of our communication level with the VA, I think it is very good. When we ask, we will certainly get an answer; and there is no problem there. I think, likely with the contract rebid issue and perhaps some other things that we don't get in on, it is more so the flurry of activity of what we are in on. The issues that we are dealing with and working with and so many things are going on at the same time, which if it doesn't get raised to our attention by, say, a veteran in the field somewhere or one of our offices, then we don't inquire whether it should have been shared or whether there could be—I am sure it could be improved.

Communication on all accounts and all levels likely can be improved. But the Commissioner has a way of finding out and knowing. Some times we just have so much going on particularly right now with the budget issues and trying to fight for survival for our programs—that what we do has likely got us tunnel-visioned on some things that we should have been in on.

Senator ISAKSON. Mr. Biro, why don't you join us up at the table. I am going to ask a question that might involve your participating in the answer. In fact, I know it will, so that is why I want you to join us.

Pete Wheeler, as represented by Tom Cook's testimony, mentioned the second Atlanta VA hospital. You did a great job of testifying as to the criteria that you go through in terms of determining outpatient clinics. Can you share with me and with the audience what criteria you go through in terms of the establishment of a new residential hospital facility?

Mr. BIRO. It is very similar to the one we talked about for Community-Based Outpatient Clinics. It is based on data. It is an actuarial model of utilization that the Department runs for us and projects the demands for many, many services—I am saying 40 or

50 services—over a period of time based on the veteran population, using a model that takes private utilization, takes VA utilization, Medicare, and does a very complex analysis of that.

Senator ISAKSON. Do you know if any analysis is being done given the Atlanta region now?

Mr. BIRO. Yes, it has been. It is finished. What the data shows is a tremendous growth in outpatient needs of several hundred thousand square feet of additional clinical space for outpatient facilities; need for residential rehabilitation for mental health patients; and what you are asking about. The acute care shows about 10 to 12 more beds, which are—

Senator ISAKSON. For acute care?

Mr. BIRO. For acute care.

Senator ISAKSON. So you need more clinical—the study indicates more clinical services, but not that much in actual bed services or residential services?

Mr. BIRO. Inpatient acute care.

Senator ISAKSON. And that service is based on what the Clairmont facility will be when the renovations are finished there?

Mr. BIRO. Yes, sir. That is correct.

Senator ISAKSON. OK. Will the Department normally, based on the study they run, make the request, or do you wait for the State through their Representatives or Senators to make the request for that consideration?

Mr. BIRO. We work off that data. As Mr. Williams pointed out, we work off that data. It is constantly updated. The appropriation is based on that data. Everything is based on that database. So we follow the plan—Senators and Representatives can ask for an exception—but we follow the plan. The Department follows the plan.

Senator ISAKSON. Well, my observation to the results that you mentioned is that one of the reasons the outpatient clinics are so successful—and I think you can tell by the nods of heads every time something like that has been said by our veterans—is that the nature of care is changing dramatically from in-bed care to outpatient care. I go to Walter Reed quite frequently to visit with our amputees and with our men and women who sacrificed, and it is remarkable—the technology that VA is applying and how those veterans are coming out of those facilities. Their needs are more for outpatient services once they come out than they are for inpatient residential service. So, I guess what you are saying is that 12 beds residential is not a huge number compared to the number we already have, but there is a shortfall of the clinical services that we need to look at.

Mr. BIRO. Yes, that is right.

Senator ISAKSON. All right. If that is the case—I am not being presumptive here and I don't want to be presumptive here, but I think Mr. Spears made reference to the same type of thing—does that beg the question that the need is a clinic, an outpatient clinic specifically for those PTSD, TBI, and other related mental health services?

Mr. BIRO. Yeah. We will proceed to get enough space. As you have already brought up, we have an application in for a health care center, which Mr. Williams talked about. We will also proceed

along a parallel line to lease several hundred thousand square feet of clinic space in the Atlanta area. So we are moving on the plan.

Senator ISAKSON. So the health care center might be one of the solutions to that problem?

Mr. BIRO. Right.

Senator ISAKSON. OK. Tom, have you got any comments on those questions? I wanted Pete to make sure you knew I asked all of them.

Mr. COOK. I believe certainly the Commissioner supports as many clinics and rehab facilities as we can open and any expansion of health care in any realm. I think the point that needs to be emphasized along with the bed space is the specialty care appointments issue. With the growth of the clinics and expansion of the clinics, particularly in the Atlanta area, the referrals to the medical center for specialty care appointments is growing, or at least that is our position—correct me if I am wrong. And if that is the case, that it is not just simply a bed issue—even though Position B would have made the hospital on the Southwest side of Atlanta—but the specialty care referrals, as well, is where we have a problem right now inside the Atlanta Medical Center—with the specialty care.

Senator ISAKSON. Well, my observation at Clairmont, I was overwhelmingly impressed with the specialty services available at Clairmont—particularly blindness, specialty services like that. I would presume, Mr. Biro, that those types of services could be accommodated in a clinical setting; because if I remember correctly, when I visited the Blind and Low-Vision Center at Clairmont, it was an outpatient part of the hospital itself, if I am not mistaken.

Mr. BIRO. Right, and I may have not been real specific. What we are saying is we are planning for not only primary care but all specialties, or the core set of specialties. So, we will have space to cover that. That requires what is happening in almost every VA is that the primary care is moving out of the main building and more specialty care is going there. But we are also going down the route of having more specialty care in the Community-Based Outpatient Clinics or remotely. So, we are moving along that way. We would take care of all needs.

Senator ISAKSON. Well, I want to thank you. I learned a lot, and I appreciate your candor. I appreciate, Tom, your raising that question, because we have received, what, hundreds, Chris, of calls regarding Clairmont—mostly over the parking right now and that inconvenience—but also about the growing demand and need, particularly because of the number of Gulf War and Iraqi Freedom and Enduring Freedom veterans who are coming back to the metropolitan Atlanta region.

Mr. Spears, my staff reminded me you were making comments with regard to the women's issue. S. 252 is expected to clear when we return. This has the pilot program for therapy in a retreat setting. It has a status report on implementation of having a Women's Veterans Coordinator in every health facility, day care for women, and things like that. So, the Committee is moving forward on those provisions and I am sorry I didn't mention that early during your comments.

Mr. SPEARS. Yes, Senator, and those coordinators are doing an outstanding job, by the way. Much of what I got was from some of those coordinators.

Senator ISAKSON. Thank you for that.

I will tell you what. Let me see, Mr. Williams, if you could pull a chair up, and let our VA lady from Augusta come up and take this chair at the end. I am going to gavel the official hearing closed so we can then respond to some questions that have been presented to me from the audience.

I would also note—Lupe, I think this is correct—I will ask unanimous consent that the record remain open for 10 days for any additional testimony you would like to submit with regard to questions I asked or any things that came up during the course of the hearing.

But now, for the purpose of Q&A, I will gavel this part of the hearing closed.

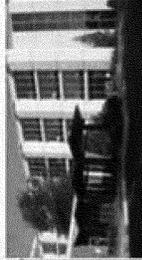
[Whereupon, at 3:50 p.m., the Committee was adjourned.]

A P P E N D I X

SOUTHWEST ATLANTA MEDICAL CENTER

501 Fairburn Road SW, Atlanta, Georgia / A 75-acre Hospital Campus with Medical Office Building





SOUTHWEST ATLANTA MEDICAL CENTER

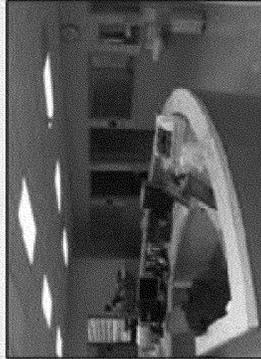
501 Fairburn Road SW, Atlanta, Georgia | A 75-acre Hospital Campus with Medical Office Building

- Multi-story, 114,297-sf turn-key acute-care hospital
- 22% of population 55+ years old
- Two-story 31,470-sf medical office building
- Current CMS and Joint Commission certification
- Suburban campus with expansion potential
- Valid Certificate of Need
- 5-mile radius population of 181,776 with \$51,059 average household income
- Strategic location with no other competing facilities within ten miles

Hospital Entrance



ICU Nursing Station



Medical Office Building





SOUTHWEST ATLANTA MEDICAL CENTER

501 Fairburn Road SW, Atlanta, Georgia | A 75-acre Hospital Campus with Medical Office Building

Hospital Description

- Multi-story building with ample surface parking (non-revenue)
- Approximately 114,297-sf
- Built in 1964; last updated 2008.
- CON approval for 125 acute-care beds
- Extensive inventory of furniture, fixtures and medical equipment available
- 1st Floor - Four OR suites, PACU, ICU, GI lab, pharmacy, laboratory, imaging, ER with two Trauma rooms, kitchen, cafeteria, storage and offices
- 2nd Floor - Administrative offices, respiratory therapy, sleep lab and mammography
- 3rd/4th Floor - Patient rooms
- Certificate of Need covers the following services:
 - Emergency
 - Inpatient
 - ICU
 - Elective Surgery

Medical Office Building Description

- Two-story building with all weather connection to hospital
- Approximately 31,470-sf
- Built in 1981

Hospital Main Entrance



Medical Office Building





SOUTHWEST ATLANTA MEDICAL CENTER

501 Fairburn Road SW, Atlanta, Georgia | A 75-acre Hospital Campus with Medical Office Building

The neighborhoods surrounding Southwest Medical Center are a vibrant mix of established middle market and up-scale single-family homes where family incomes are above average. Plus there is a healthy assortment of multi-family, retail, office and commercial uses. Retailers serving this market include Publix, Kroger, Walgreen's, Starbucks, Applebee's, Wendy's, KFC, Wachovia, SunTrust, and Home Depot. Two of the newer public facilities in the neighborhood are the Southwest Branch of Atlanta-Fulton County Public Library System and the Southwest Arts Center — both are emblematic of the gentrification of this growing market area.

Location and access are vital to the growth and sustainability of any market, and Southwest Medical Center is no exception. This is a close-in suburban market that lies at the southwest intersection of I-285 and I-20 which provide quick and direct access to the central business district, Atlanta Hartsfield International Airport and to all major employment centers. On-ramps to both interstates are about one mile from the property.



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SOUTHWEST ATLANTA MEDICAL CENTER

501 Fairburn Road SW, Atlanta, Georgia | A 75-acre Hospital Campus with Medical Office Building

Southwest Medical Center is located in the City of Atlanta, Fulton County. The property location is bounded by Interstate 20 to the north, Cascade Road to the south, Interstate 285 to the east, and Fulton Industrial Boulevard to the west.

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