

**Statement of the
VISN 7 Executive Leadership Panel
Department of Veterans Affairs
before the
CARES Commission
on the
Atlanta Network Market Plans**

August 2003

Mr. Chairman and members of the Commission, I am pleased to be here today to discuss the Atlanta Network's CARES Market Plans. This Atlanta hearing will focus on our Alabama and Georgia markets. We will address the South Carolina market at the September 8th hearing in Charleston.

Our formal testimony will:

- Describe the CARES planning process in VISN 7,
- Briefly outline VISN 7's geographic area,
- Provide an overview of CARES-identified needs in VISN 7,
- Describe the Alabama and Georgia market areas,
- Provide an overview of CARES projections for these two markets,
- And, describe specific CARES issues and plans that affect Alabama and Georgia.

CARES Planning Process

The VISN 7 CARES Steering Committee provides the strategic leadership for CARES in VISN 7. The Steering Committee membership includes the directors and chiefs of staff from all eight VISN 7 VAMCs, all network-level service line directors, the three state directors of veterans' affairs, VISN 7 union representatives, DoD principals, and Veterans Benefits Administration (VBA) and National Cemetery Administration (NCA) representatives. The Steering Committee met several times during the past year for 1) initial briefings on the Planning Initiatives that were identified for VISN 7, 2) strategic sessions to identify solutions for those Planning Initiatives, and 3) to approve the key elements that form the basis of VISN 7's CARES Plan. The Steering Committee is continuously informed via email of all CARES developments and information disseminated by the National CARES Planning Office (NCPO) and the VSSC CARES support staff. Since the last full Steering Committee meeting and the submission of our CARES Plan, the VISN 7 Executive Leadership Council (which comprises the majority of the Steering Committee) is updated at least quarterly on CARES at their face-to-face meetings.

Three individuals in the Network Office served as VISN 7's CARES Coordinators, each focusing on a single market. These individuals worked closely with the CARES Coordinators at each of the VAMCs in their respective markets to develop the plans, including workload and space mappings, identifying new CBOC locations, contract solutions, space shortage solutions, and vacant space solutions. In turn, the facility CARES Coordinators worked closely with key individuals and decision-making bodies at their facilities to develop those plans and solutions.

Two VISN 7 Service Lines had major roles in developing strategies and/or background information to include in our CARES Plan. The Primary Care Service Line, which handles VISN 7's CBOC strategic planning, assisted in identifying locations for new CBOCs. The Acute Care Service Line, which oversees acute inpatient and specialty care services, conducted the "Proximity" and "Small Facility" analyses.

VISN 7 conducted an intensive communications program throughout the planning process, which continues today. At the facility-level, the Public Affairs Officer and the CARES Coordinator disseminate CARES information to stakeholders in the form of email, newsletters, town hall meetings, flyers, briefings, etc. Each facility conducted at least two formal town hall-style briefings at key points during the planning process—1) to describe the Planning Initiatives that were identified for the VISN and market, and 2) to describe the proposed strategies that would form the basis of the VISN's CARES Plan and to seek input and alternative strategies. VISN 7 submits detailed reports each month to the NCPO of all CARES communication events.

At the network level, numerous stakeholder outreach and briefing events were conducted including a face-to-face briefing for our state directors of veterans' affairs and video- and audio-conference briefings for union leaders. VISN 7 and facility CARES Coordinators, Chiefs of Staff, and Directors have also conducted individual briefings for affiliated medical school deans and Dean's Committees.

Please note that the late-breaking national additions to VISN 7's Draft CARES Plan, including the Central Alabama Veterans Healthcare System (CAVHCS) and Augusta realignment recommendations and certain aspects of the Dublin small facility recommendation, were not fully addressed with our stakeholders. The period for stakeholder input on these newer elements is now, and for the next 60 days.

VISN 7 Geographic Area

The Atlanta Network serves veterans from economically and demographically diverse areas within three states (the entire state of South Carolina, and most of Georgia and Alabama). The Network includes eight VA medical centers, including two two-division medical centers. In Alabama, we have VAMCs in Tuscaloosa and Birmingham, and CAVHCS, which has two divisions—one in Montgomery and the other in Tuskegee. There are three VAMCs in Georgia—VAMCs Atlanta, Dublin, and Augusta. The Augusta VAMC has two divisions just a few miles apart—the Downtown Division and the Uptown Division. And, in South Carolina, we have VAMCs Charleston and Columbia. All the VAMCs except Augusta and Tuscaloosa, operate several CBOCs. We have 23 CBOCs at this time strategically located across the network. Please note that the southernmost counties of Georgia are part of VISN 8, and the southwestern panhandle of Alabama is part of VISN 16. Most of VISN 7 is rural and medically underserved.

VISN 7 Market Areas

Three market areas were defined in VISN 7 for CARES planning purposes. These areas only roughly correspond with the three states' boundaries. The Alabama market area also includes parts of west-central Georgia, and the Georgia market also includes parts of west-central South Carolina. Market definitions accommodated current and projected referral patterns between VAMCs and CBOCs. There are no significant travel barriers in VISN 7, other than traffic congestion in the most urban areas, especially Atlanta and Birmingham.

VISN 7 CARES Overview

Since this is the first of two hearings planned for VISN 7, it may be useful to provide a “big picture” of what the CARES process has identified as needs or gaps in VISN 7.

The key word for VISN 7 is “growth”. Significant enrollee growth is projected for all three of our markets across the 20-year planning period. Despite a projected *decrease* in veteran *population*, the number of *enrollees* is projected to *increase* over the planning period (due to recent increases in enrollment rates, which are projected to continue). While our 2001 base-line penetration rate (enrollees/vet pop) was just 23% (this is relatively low; note especially the 19% penetration rate in Georgia), the rate is projected to reach 33% by 2022:

Market Name	2001 Enrollees	2001 Penetration Rate	2012 Enrollees	2012 Penetration Rate	2022 Enrollees	2022 Penetration Rate
Alabama	106,774	26%	120,560	33%	114,063	36%
Georgia	122,419	19%	156,454	27%	159,114	31%
South Carolina	106,015	24%	118,898	30%	115,444	33%
Total	335,208	23%	395,912	30%	388,621	33%

Outpatient workloads are projected to increase by 50% by 2022; acute inpatient workloads are projected to increase by 11% by 2022. The gaps are larger in 2012 (57% and 26%, respectively) when workloads are projected to peak. Access and capacity shortages were identified for all three markets. Outpatient capacity gaps are especially large in the areas of primary care, specialty care and ancillary/diagnostic care. Access and capacity gaps are significant to the extent that all fifteen of the new CBOCs in our CARES Plan were assigned to the highest priority group in the Draft National Plan. Only 48 CBOCs nationwide were assigned to this top priority group; almost a third of them are VISN 7's.

Acute inpatient workloads (medicine, surgery and psychiatry) are also projected to increase, with peaks in 2012. To accommodate these workload increases, additional bed capacity is planned for most of our medical centers.

Special disability programs are addressed in CARES as network-level resources, rather than market-specific resources. Projections for spinal cord injury care needs have identified a need for 26 additional SCI beds at our Augusta facility. Our Blind Rehabilitation Center capacity is adequate.

The other significant CARES issues that pertain to VISN7 include the identification of Dublin as a “Small Facility”, the proximity of three of our tertiary VAMCs (VAMCs Augusta and Charleston to VAMC Columbia), and the realignment recommendations in the Draft National Plan relative to our two-division VAMCs, CAVHCS and Augusta.

There are numerous vacant and excess buildings on the Tuskegee and Uptown Augusta campuses. Changes over the years in how patient care is delivered (shift to outpatient care), administrative consolidations, replacement facilities, discontinuance of quarters and a merger (CAVHCS) are all factors. The Augusta and Tuskegee original buildings

date to 1913 and 1923, respectively. They are in very poor condition and are unsalvageable. An independent consultant assessed the potential for alternative uses and concluded that demolition would be in the government's best interest. Due to the buildings' historic interest, demolition requires coordination with state historic preservation offices.

Alabama Market Description

This market area consists of the majority of the state of Alabama and parts of west central Georgia. 73% of the counties in this market are considered rural, and most of the area is medically underserved. The tertiary referral center in the Alabama market is VAMC Birmingham, which has a strong academic affiliation with the adjacent University of Alabama Medical School. Birmingham offers a Blind Rehabilitation Center (one of two in VISN 7), and the full range of inpatient and outpatient programs. About one hour southwest of Birmingham is VAMC Tuscaloosa. The Tuscaloosa facility's main mission is long-term care and psychiatry, but it also offers primary care. Moving south, CAVHCS' two divisions have complementary missions. The West Campus (Montgomery) offers inpatient medicine and surgery, as well as outpatient clinics in most specialty areas. The VA Regional Office is located on the campus of the Montgomery facility. The East Campus (Tuskegee) has a long-term care and psychiatry mission, but also offers primary care. The formerly independent Tuskegee and Montgomery VAMCs were merged in 1997. The Alabama market has CBOCs in Huntsville, Madison/Decatur, Shoals/Sheffield, Gadsden, Oxford/Anniston, Jasper, Dothan, and Columbus (GA).

Special mention should be made of the Tuskegee Campus' place in African-American History. The Tuskegee Veterans Hospital was built in 1921 and was the only Veterans Hospital for African-American World War I veterans, until VA health care was later integrated. The Tuskegee community itself is a major stop on the Black Heritage Trail. The Tuskegee Institute National Historic Site includes the home of Booker T. Washington, the George Washington Carver Museum, and the historic Tuskegee University. The famed Tuskegee Airmen of World War II learned to fly at the Tuskegee Army Air Field.

Alabama CARES Projections, Gaps, and Proposed Solutions

o **Workload Projections**

Alabama faces significant capacity gaps (workload increases) in outpatient primary and specialty care, and inpatient medicine and surgery:

Category	2001 Baseline	Increase by 2012	Increase by 2022
Primary Care (stops)	290,172	35%	17%
Specialty Care (stops)	200,149	93%	77%
Ancillary/Diagnostic (stops)	930,354	61%	63%
Medicine (BDOC)	35,976	66%	34%
Surgery (BDOC)	13,609	65%	34%

Expanding current sites of care and adding five new CBOCs in Bessemer, Childersburg, Guntersville, Opelika, and Enterprise will address these capacity gaps. The new Bessemer CBOC will be a large, multi-specialty clinic. The current Huntsville CBOC (now in leased space) will be replaced with a large newly constructed multi-specialty clinic.

- **Bed Capacity**

Birmingham will add medicine and surgery bed capacity by converting currently available space. CAVHCS West will add medicine beds with new construction. CAVHCS East will add psychiatry beds by converting currently available space.

- **Access**

Alabama has access gaps based on excessive drive times for both primary care and hospital care. Only 63% of Alabama enrollees live within a 30-minute drive of primary care (target is 70%); only 53% of Alabama enrollees live within a one-hour drive of hospital care (target is 65%). The addition of the five CBOCs previously mentioned, phased in over the next few years, will raise the primary care access to 70% by 2012. Hospital care contracts are planned in the Dothan and Huntsville communities, which will raise Alabama's hospital access to 65% by 2012. All CBOCs are planned to deliver mental health services, at the rate of either the nationally benchmarked rate of 20% of primary care workload volume, or actual historical volume, whichever is greater.

- **Realignment Proposal—CAVHCS**

CAVHCS was one of the two-division facilities that the Under Secretary for Health flagged for potential "realignment", i.e., conversion of either the West (Montgomery) or the East (Tuskegee) Campus to an outpatient-only facility. This realignment scenario is not in VISN 7's Draft CARES Plan, but is an "add-on" element in the Draft National Plan. In response to the USH request, VISN 7 developed a scenario for potential conversion of the West Campus. Conversion of the West Campus to an eight-hour operation would require contracting out all medical/surgical inpatient and after-hours urgent/emergent care, while a conversion of the East Campus would require either VA replacement of hundreds of long-term care (NHCU and Domiciliary) and psychiatry beds, or purchase of these services from non-VA sources, which are scarce, expensive, and not comparable. CAVHCS West was chosen as more feasible for conversion than CAVHCS East. Although some of the realignments that were proposed nationwide were selected to proceed, and described as such in the Draft National Plan, the CAVHCS realignment was not. Instead, the CAVHCS realignment "requires further study", per the Draft National Plan. We anticipate additional instructions from the Under Secretary for Health and the National CARES Planning Office on how to complete the conversion analysis. Maxwell AFB's 42nd Medical Group and CAVHCS are currently discussing sharing opportunities. Maxwell has needs in various areas including surgery, anesthesia, and orthopedics. Clearly, any opportunities for CAVHCS to meet DoD's needs should be factored into the realignment evaluation.

- **Space**

Based on the CARES workload and space projection models, existing infrastructure at two of the Alabama VAMCs significantly exceeds needs. The East Campus of CAVHCS (Tuskegee) will have over 300,000 excess square feet (located in multiple buildings,

mostly vacant outbuildings) by 2022. The majority of this space (~250,000) is planned for demolition due to its age, condition, remote location, and poor potential for alternative uses. The Tuscaloosa VAMC is also projected to have a large amount of excess space—113,000 square feet (located in multiple buildings campus-wide) by 2022. The plan for Tuscaloosa's excess infrastructure is to lease most of it to an interested private mental health group in the community (~100,000 square feet), which is already leasing space at the facility. This use nicely complements Tuscaloosa VAMC's mission and provides a revenue stream that supports patient programs.

Both CAVHCS West and Birmingham VAMC will need constructed additions to handle projected workload increases. These additions are sized using the "space calculator" that was built into the CARES market plan software. A parking addition is also planned for construction at Birmingham. Also, a new dietetic facility (~12,000 square feet) is planned for construction at VAMC Tuscaloosa. This facility will produce meals for sale to the local Meals on Wheels, Indian Rivers Mental Health and the new private Hospice of West Alabama, which is under construction on the Tuscaloosa campus (Enhanced Use Project).

Additional space will also be leased to support workload increases. Current CBOCs will be moved to larger leased space, as necessary. Mental health clinics at CAVHCS West will be moved to leased space in order to free up space at the VAMC to support other clinics' expansion needs.

- **Research**

Birmingham has the largest research portfolio in Alabama (~\$6.5 million in FY 01). Based on the CARES research space formula, Birmingham needs to lease an additional 5,000 square feet of space. This lease is in the CARES Plan. No other Alabama facility has a need for additional research space.

- **DoD Collaborative Plans**

VISN 7 was unable to plan to meet its hospital access gaps by purchasing inpatient care from DoD. Our geographic areas of need are Huntsville and Dothan AL. There is no DoD inpatient facility in the Huntsville area since Fox Army Hospital closed their beds several years ago. Therefore, our plan to meet the hospital access gap in northern Alabama is to purchase episodes of inpatient care from Huntsville community hospitals. Although our current plan for the Dothan area is to purchase inpatient care from community hospitals, CAVHCS is exploring alternative joint VA/DoD options with Lyster Army Hospital in nearby Ft. Rucker.

Similarly, VISN7's needs to add primary care access points could not be satisfied by DoD health care facilities in this first planning cycle. Our access point needs were geographically specific, based on where enrollees live, and distance to current care sites. The only gap location that is near a DoD clinic is in Enterprise, AL. Ft. Rucker's Lyster Army Hospital is very near Enterprise. The Enterprise location was chosen for a new CBOC with the intent to pursue shared services (e.g., outpatient surgery and specialty care) with Lyster. Since that CBOC is not planned to open until FY 10, there will be ample time to collaborate with DoD on this clinic initiative.

CAVHCS is exploring numerous future options for joint ventures with Maxwell Air Force Base, Ft. Rucker and Ft. Benning. These options include space, workload, and other

resource sharing. Since CAVHCS' primary service area includes three military bases with medical treatment facilities, there is enormous potential for future resource sharing.

Georgia Market Description

The Georgia Market consists of the majority of the state of Georgia and parts of west central South Carolina. 76% of the counties in this service market are considered rural, and most of the area is medically underserved. The two tertiary VAMCs are Atlanta (in the suburb of Decatur) and Augusta. VAMC Atlanta is affiliated with nearby Emory University and offers the full range of inpatient and outpatient services. The Atlanta VA Regional Office was co-located next door to the VAMC Atlanta a few years ago. As with CAVHCS, Augusta's two divisions have complementary missions. The highly affiliated (Medical College of Georgia) Augusta VAMC houses the VISN's only SCI unit, and a full range of inpatient and outpatient programs (a VA/DoD jointly operated cardiac surgery program is conducted at Eisenhower Army Medical Center and a jointly operated neurosurgery program is conducted at VAMC Augusta's Downtown Division). A few miles north, the Uptown Division has a Blind Rehabilitation Center and offers long-term care and psychiatry programs. In Southern Georgia, the Dublin VAMC offers a small medical/surgical inpatient program and long-term care. Dublin refers patients to both Atlanta and Augusta for tertiary care. There are CBOCs in Midtown Atlanta, Smyrna, Oakwood, Lawrenceville, Macon, and Albany. (The Savannah GA CBOC is in the South Carolina market and the Columbus GA CBOC is in the Alabama market.)

Georgia CARES Projections, Gaps and Proposed Solutions

o **Workload Projections**

Georgia faces significant capacity gaps (workload increases) in outpatient specialty and primary care. There is a less significant capacity gap in inpatient medicine. The other CARES clinical workload categories will hold fairly constant through the twenty-year planning period:

Category	2001 Baseline	Increase by 2012	Increase by 2022
Primary Care (stops)	288,728	62%	52%
Specialty Care (stops)	287,274	86%	90%
Medicine (BDOC)	52,714	19%	11%

Expanding current sites of care and adding eight new CBOCs in East Point, Athens, Perry, Stockbridge, Newnan, Brunswick, Milledgeville and Aiken (SC) will address these capacity gaps. The new Stockbridge CBOC will be a large multi-specialty clinic. Also, the CBOC currently located in Lawrenceville will be enlarged to create large multi-specialty clinics. Studying suburban Atlanta with "mega" CBOCs will serve to decompress the VAMC in Decatur, which is already struggling with space deficits.

o **Bed Capacity**

The Atlanta VAMC will add medicine and psychiatry beds by converting currently available space. Psychiatry beds will be added at Uptown Augusta, also by converting current space.

- **Access**

Georgia has primary care access gaps based on excessive drive times. Only 55% of Georgia enrollees live within a 30-minute drive of primary care (target is 70%). The addition of the eight CBOCs listed above, phased in over the next few years, will raise the primary care access percentage to 70% by 2012. Hospital access is not an issue in Georgia since 80% of enrollees already live within an hour's drive of hospital care. All CBOCs are planned to deliver mental health services, at the rate of either the nationally benchmarked rate of 20% of primary care workload volume, or actual historical volume, whichever is greater.

- **Realignment Proposal—Augusta**

Following the submission of VISN 7's CARES Plan, the Under Secretary for Health identified Augusta's Uptown Division for potential "realignment", i.e., conversion to an outpatient-only facility. In response, VISN 7 submitted a concept paper that described a scenario for transferring Uptown's inpatient programs to other VISN 7 VAMCs, and contracting out a portion to the private sector. A preliminary cost/savings analysis for the conversion scenario indicates that additional contract costs would greatly exceed the recurring savings that would result from the mission reduction. A substantial construction outlay would also be required to relocate functions from the Uptown Division to the Downtown Division. This scenario for conversion to "outpatient only" was not selected to move ahead in the Draft National Plan. Instead, the DNP recommends that the Augusta VAMC could benefit from additional "footprint" contraction (either by contracting out or shifting programs to other VA campuses), so as to maximize potential for Enhanced Use opportunities, and that additional VA/DoD (with nearby Eisenhower Army Medical Center) joint ventures should be explored. We await additional instructions from the USH as far as what additional analyses will be required.

- **Small Facility PI—Dublin**

The Dublin VA Medical Center was flagged as a "small facility" in the Planning Initiative identification process, due to the small size of its acute inpatient program (bed needs projected at less than 40). The medical center currently has 33 acute beds, including four surgery beds and six ICU beds. There were nineteen "small facilities" reviewed nationwide. Each required a comprehensive analysis of quality of care, community resources, physical condition, patient satisfaction, costs, etc. The outcome of each review led the VISN to recommend either retention of the acute beds, or closure, with referral of workload to other VAMCs and/or community contracts. As a result of its analysis, VISN 7 recommended retention of Dublin's acute beds. (A summary of VISN 7's "small facility" analysis is in our CARES Plan, with additional supporting documentation posted on the CARES "Portal".) VISN 7's recommendation to retain Dublin's acute beds is endorsed in the Draft National Plan, with the exceptions that the several surgery beds at Dublin would be "transitioned" to observation beds, and that ICU bed needs would be "evaluated". Please note that nearby Robins Air Force Base's 78th Medical Group has recently expressed interest in purchasing surgical services from VAMC Dublin. Since this interest is new, it was not included in VISN 7's "small facility" analysis. However, this new information should be considered before any final decision is made regarding Dublin's surgery beds.

- **Spinal Cord Injury Unit**

As mentioned in the VISN 7 overview, the SCI Unit at VAMC Augusta (Downtown) is a network resource. The SCI planning model predicts a need for 26 additional beds, to reach a total of 86 beds by 2022. A minor construction project is nearly complete to bring the current beds to VA standards. Another minor construction project is scheduled for FY 04 that addresses insufficient outpatient space. The VISN 7 Plan is to construct new space for the additional 26 beds. We are targeting to add eleven beds in 2006 and the remaining fifteen beds in 2012.

- **Space**

The Georgia market's vacant space is largely concentrated at the Augusta Uptown Division, since multiple old buildings were left standing when the replacement facility was completed in 1990. Approximately 300,000 square feet of building space will be vacant by 2022. The VISN 7 Plan would demolish several of these buildings (~200,000 square feet), since they have no enhanced use potential, and the cost to repair the buildings, including asbestos and lead paint removal, would greatly exceed the cost of demolition. The Historic Preservation Division of the Georgia Department of Natural Resources conducted a site visit in April of this year and replied to us in writing on August 12 that they continue to support preservation of all of the buildings in question.

As described above, the Atlanta VAMC already is severely space-constrained. There are three main strategies: 1) create additional space by relocating primary care services out of the medical center and into CBOCs, with the addition of several new metro-area CBOCs, 2) relocate research programs into new construction (discussed more fully later in this paper), and 3) contract out ever increasing amounts of ancillary/diagnostic workloads over the planning period.

Additional space will also be leased to support expansion of workload at current VA-staffed CBOCs, market-wide as necessary.

Parking additions are planned for construction at Atlanta and Augusta (Downtown Division).

- **Facility Condition**

Early in the CARES Planning Initiative identification process, the Atlanta VAMC was identified in critical need of ward renovations. Therefore, VISN 7's CARES Plan includes construction projects for Atlanta to modernize three patient wards in order to meet community standards.

- **Research**

The only Georgia facility that is short on research space is Atlanta. Atlanta has a large and rapidly growing research program and will need an additional 23,000 square feet. The solution in the VISN Plan is to lease the required space until new construction can resolve the need in FY 06. Atlanta is pursuing a revocable lease arrangement whereby the private Atlanta Research Foundation would put up a new modular building on the Atlanta campus, leasing it to VAMC Atlanta for ten years, after which time the building reverts to VA ownership. This would accomplish two things: first, it would double the

space available for research, and second, it would free up needed space in the medical center for patient care programs.

- **DoD Collaborative Plans**

Similar to the situation in Alabama, VISN7's needs to add primary care access points in Georgia could not be satisfied by DoD health care facilities in this planning cycle. Our access point needs were geographically specific, based on where enrollees live, and distance to current care sites. The only gap location that is near a DoD clinic is in South Fulton County. The current Midtown Atlanta CBOC is planned for relocation to that area (East Point). Although the Lawrence Joel Army Health Clinic is nearby at Ft. McPherson, they cannot accommodate a new VA clinic on their base at this time. However, we will continue to explore other collaborative opportunities with Ft. McPherson.

VAMC Dublin already sells pathologist services to nearby Robins Air Force Base. Additional sharing agreements (VA selling services) are under development in the areas of substance abuse treatment and surgery. (If the final CARES decision is to close Dublin's surgical beds, we will not be able to meet any of Robins' inpatient surgery needs.)

The Augusta VAMC and Eisenhower Army Medical Center at Ft. Gordon entered into a "Joint Venture for Shared Services" agreement in 1992. They have merged the service delivery of neurosurgery, cardio-thoracic surgery and OB/GYN via this agreement. Cost avoidance is estimated at \$1.1 million per year as a result of these shared services. As discussed in the "realignment" section above, the Draft National Plan calls for even greater coordination of VA/DoD (Eisenhower Army Medical Center) services. The VA/DoD "cluster" of healthcare facilities in Augusta (EAMC, and the Augusta VAMCs Uptown and Downtown Divisions) represent a high potential for additional collaboration. VISN 7 and regional DoD officials have launched a new "Tiger Team" to expedite new collaborative initiatives. This group is now reviewing pilot project applications for implementation and for potential submission for national funding under the FY 2003 National Defense Authorization Act (NDAA).

- **Summary**

In summary, VISN 7 is in a major expansion mode, due to projected enrollment and workload increases. Additional clinic and bed capacity will be needed to support the workload increases. Fifteen CBOCs will be added network-wide, with twelve in Georgia and Alabama, and all fifteen have been given the highest priority in the Draft National Plan, since they not only meet access needs, they also create the additional capacity we will need.

We have numerous excess and vacant buildings at two of our campuses—Augusta and Tuskegee. It is not economically feasible to recondition and operate these buildings. The buildings have no potential for alternative uses and are proposed for demolition. Our plans are complicated by the fact that all of these buildings have historic significance. A demolition proposal package was submitted to Georgia's State Historic Preservation Division. We just received their response, which recommends preservation of the buildings-- preferably with compatible alternative uses, alternatively by mothballing. Initial contacts have also been made to Alabama's historic preservation group regarding the Tuskegee buildings.

We have two two-division VAMCs in VISN 7—Augusta and CAVHCS. As such, they were flagged for realignment concept studies. In both cases, the two divisions have eliminated duplication of inpatient services, resulting in complementary missions. The Draft National Plan indicates that the CAVHCS realignment to “outpatient only” requires further study. The DNP has dropped language regarding an Augusta conversion. Instead, it recommends that Augusta should attempt to free up more of its Uptown campus, in order to position it for more EU opportunities, and that Augusta should pursue more joint programs with DoD. Both campuses of both medical centers will remain open.

Retention of the Dublin VAMC’s small inpatient program was upheld in the Draft National Plan, based on quality of care, access, cost and other factors. However, the Draft National Plan does call for phasing out Dublin’s few surgery beds, due to the clinical proficiency implications associated with low volume programs. New information on DoD’s surgical needs in the Macon/Dublin area should bear on the surgery bed decision.

VISN 7 has produced a Draft CARES Plan that addresses our needs in a realistic and responsible way. We welcome your questions.