

**STATEMENT OF
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OF THE SOUTH CENTRAL VA HEALTH CARE NETWORK (VISN 16)
BEFORE THE CAPITAL ASSET REALIGNMENT FOR ENHANCED SERVICES
(CARES) COMMISSION
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Muskogee VA Medical Center
Muskogee, Oklahoma**

Good morning, Commissioners. On behalf of the South Central VA Health Care Network, let me welcome you to the Muskogee VA Medical Center. We're honored to have you here today.

Thank you for the opportunity to appear before your commission today and testify about Capital Asset Realignment for Enhanced Services, the national VA initiative known as CARES. Joining me on the panel are: Mr. George Gray, director of the Central Arkansas Veterans Healthcare System, Mr. Steve Gentling, director of the Oklahoma City VA Medical Center, Mr. Michael Winn, director of the Fayetteville VA Medical Center, and our host for today's hearing, Ms. Melinda Murphy, director of the Muskogee VA Medical Center. After my opening statement, we will all be available for questions.

My name is Robert Lynch. I am the director of the South Central VA Health Care Network, Veterans Integrated Service Network 16. Prior to my current position, I served as chief of staff at the G.V. (Sonny) Montgomery VA Medical Center. Prior to that, I served as associate chief of staff for what used to be the VA Southern Region. As a veteran, it has been my great privilege to serve veterans as a VA employee for more than 20 years.

Network 16 consists of 10 medical centers, 30 community-based clinics, and two domiciliaries and includes all or part of the following states – Florida, Alabama, Mississippi, Louisiana, Texas, Arkansas, Oklahoma, and Missouri. By geography, it is the second largest of VHA's 21 Veterans Integrated Service Networks. More than 400,000 veterans will receive treatment from one of our network facilities. We are currently the second largest network. Approximately 16,000 employees work for the network.

Over the last eight years, our network, like all of VA, has transformed itself as health care delivery system. We have shifted our services away from an outdated inpatient model of care to an outpatient model that brings health care closer to the veteran as well as emphasizes prevention and education. VA is now recognized as a model of excellence in the health care community. Our accreditation scores and veterans surveys consistently reflect the high level of care veterans receive from VA.

I believe it is important to view CARES through the prism of VA's transformation. I firmly believe that CARES offers our network, as well as all of VA, a road map to build on successes made over nearly a decade of hard work. We are proud of the changes we've made and the services we provide veterans. However, we cannot stand still. We cannot – excuse the cliché – rest on our laurels. We must look forward to ensure veterans find a health care system that is prepared to provide them the same level – if not greater – of services in 5 years, in 10 years, and in 20 years.

CARES provides such a strategic road map. Our network is defined by its largely rural population coupled with a consistently growing veteran population. For years, improving access and enhancing services for veterans have been great challenges for our network. Prior to CARES, we identified these challenges. Through our strategic planning process, we developed short, medium and long term tactics to address these challenges.

We have integrated our strategic goals with CARES. Ultimately, I believe CARES brings greater focus to our network's strategic goals.

VA's CARES National Draft Plan adopts market plans that our network developed and recommended as part of this process to realign and enhance veterans' health care services for the decades to come.

To address CARES, our network defined four geographic markets – the Eastern Southern, which includes gulf coast areas of Alabama and Florida, the Central Southern, which includes 80 counties and parishes in Mississippi and Louisiana, the Central Lower, which includes 84 counties and parishes in Texas and Louisiana and five border counties in Arkansas, and the Upper Western, which includes 132 counties in Oklahoma, Texas, Arkansas, and Missouri.

Today, of course, we are meeting about the Upper Western Market. The network's Upper Western Market includes the Central Arkansas Veterans Healthcare System, the Fayetteville VA Medical Center, the Muskogee VA Medical Center, and the Oklahoma VA Medical Center. It also includes community-based outpatient clinics in Mt. Vernon, Ark., Harrison, Ark., Fort Smith, Ark., Mountain Home, Ark., El Dorado, Ark., Hot Springs, Ark., Tulsa, Okla., McAlester, Okla., Lawton, Okla., Wichita Falls, Tex., Ponca City, Okla., Clinton, Okla., Ardmore, Okla., and Konawa (Seminole County), Okla.

Our market plan, adopted in the Draft National Plan, includes a major clinical addition at the Fayetteville VA Medical Center, the creation of a spinal cord injury unit at the Central Arkansas Veterans Healthcare System, and an expanded mission for the Muskogee VA Medical Center.

What follows is a list of our network's recommendations to address project gaps in services, or planning initiatives, that were identified by VA Central Office.

1. **GAP:** Access to primary care. In this market, 54 percent of veterans were within a driving distance established by VA Central Office. CARES set 70 percent as the target. As an optimal standard, CARES establishes the following guidelines: in urban and rural areas, veterans should be within a 30 minute drive of a VA health care provider. In highly rural areas, veterans should be within a 60 minute drive of a VA health care provider.
RECOMMENDATION: We recommend opening 16 community-based outpatient clinics in the following areas: Springfield, Mo., Jay, Okla., Webb City, Mo., Branson, Mo., Ozark, Ark., Bella Vista, Ark., Mena, Ark., Searcy, Ark., Conway, Ark. Pine Bluff, Ark., Russellville, Ark., Vinita, Okla., Talihina, Okla., Enid, Okla., Altus, Okla., and Stillwater, Okla.
NOTE: The Draft National Plan adopts this recommendation. All recommended clinics for the Upper Western market are included in the plan's second priority group.

2. **GAP:** Inpatient medicine beds. In this market, an 18 percent gap is projected in 2022 in demand for inpatient services.
RECOMMENDATION: We recommend increasing the number of both medicine and surgery inpatient beds to meet 2022 bed projections within existing facilities. The Oklahoma City VA Medical Center and Central Arkansas Veterans Healthcare System will meet demands in peak years within the community using contracts and reallocation of some workload to Muskogee VA Medical. The Fayetteville VA Medical Center will also shift some workload to Muskogee. A 20-bed medicine unit would be established at the Muskogee VA Medical Center to address the need for additional medicine beds. In addition, existing hoptels and leased space at Oklahoma City and Central Arkansas' Little Rock facility would be converted for projected acute medicine beds.

3. **GAP:** Outpatient primary care. In this market, a 21 percent gap is projected in 2022 in demand for outpatient primary care services.
RECOMMENDATION: We recommend reopening community-based outpatient clinics in Ardmore, Okla. and Clinton, Okla. and expanding hours of operation. Primary care will be expanded by six rooms through consolidation of staff offices at Central Arkansas' North Little Rock facility. In addition, our plans call for expanding capacity at community-based outpatient clinics at Mt. Vernon, Mo., Harrison, Ark., Fort Smith, Ark., Mt. Home, Ark., Hot Springs, Ark., Tulsa, Okla., McAlister, Okla., Wichita Falls, Tex., and Konawa, Okla.

4. **GAP:** Outpatient specialty care. In this market, an 87 percent gap is projected in 2022 in demand for outpatient specialty care services.
RECOMMENDATION: We recommend a major capital investment for a clinical addition at the Fayetteville VA Medical Center to provide specialty services. The Fayetteville facility is a small hospital that is bursting at the seams as it continues to see large increases in veterans seeking services. (Fayetteville, Ark. is one of the ten fastest growing areas in the country.) In addition, Oklahoma City and Central Arkansas will explore establishing primary care clinics in the local community in order to provide space for expansion of specialty care at the parent facilities. Where space is available, each medical center will provide additional specialists.

5. **GAP:** Inpatient psychiatry services. In this market, a 28 percent gap is projected in 2022 in demand for inpatient psychiatry services.
RECOMMENDATION: We recommend a proposed minor construction project at Oklahoma City that will provide an additional eight inpatient psychiatry beds. Muskogee will renovate a vacant bed unit to establish an inpatient psychiatric unit and support some reallocated workload. Fayetteville and Central Arkansas will also expand their capacity to meet the additional beds projected.

6. **GAP:** Small facility planning initiative. The Muskogee VA Medical Center is projected to require only 36 beds in 2012 and 27 beds in 2022. The national initiative calls for justification of a continued inpatient presence.
RECOMMENDATION: We recommend the Muskogee VA Medical Center retain its existing acute bed workload. In addition, Muskogee's mission would be expanded to include establishing a 20-bed short-term rehabilitation medicine program and converting a vacant inpatient unit to an inpatient psychiatric unit.

7. **GAP:** Special populations. VA Central Office identified a gap in spinal cord injury services in the network.
RECOMMENDATION: Because of its location, academic affiliations, and current infrastructure, we recommend establishing a spinal cord injury unit at the Central Arkansas Veteran Healthcare System.

Finally, I'll mention that CARES encourages VA to think outside the box, to look for opportunities to work with other organizations and institutions to ensure veterans continue to receive quality health care well in to the future. I applaud such efforts. I'm pleased to say in this market we currently are participating in collaborative relationships with the Veterans Benefits Administration, with the Department of Defense, and the Bureau of Indian Health. We will continue to seek opportunities to further enhance such collaborations.

That concludes my testimony. Again, thank you for this opportunity to appear before your commission. My colleagues and I will be pleased to answer any questions.