
Statement *of Patrick Russell, Co-chair of the Hot Springs Save the VA Committee*

I am Patrick Russell, President of the American Federation of Government Employees Local 1539 representing the employees of the Hot Springs VA Medical Center, an army veteran and Co-chair of the Hot Springs Save the VA Committee.

Little to no analysis was conducted prior to making the decision to close the Hot Springs, South Dakota VA Medical Center and replace it with a Community Based Outpatient Clinic (CBOC) and move the 100 bed treatment facility to an urban area in Rapid City, South Dakota. All subsequent analysis appears to cherry pick the data to support this predetermined proposal. The proposal itself appears to consist solely of a power point presentation, as the Freedom of Information Act (FOIA) requests submitted by the Save the VA Campaign did not produce any documents which supported the VA's assertions of economy or quality of care.

Despite the fact Dr. Petzel states in his September 14, 2012, testimony to a congressional subcommittee that VA care is the first choice, it appears from VA BHHCS' management decisions the first choice is to contract services with the private sector. That is what their proposal states. This is already reflected in the astronomical contractual fees being paid out by VA BHHCS. For example, the amount of money paid to the Hot Springs ambulance service has risen from \$77,736 2001 to over a half million dollars per year in 2011 per FOIA request 2012-0038.

Many of the services previously provided at HS VAMC have been discontinued, forcing veterans to travel an additional 90 minutes. For example, colonoscopies and other routine preventive procedures were provided at HS VAMC as recently as two years ago. There have been no provisions made to provide services closer to home. In fact, all that has been accomplished is the ability of VA BHHCS Administration to say the demand for a particular service has declined. Of course, this is because it is no longer available.

Discontinued Clinical Services at Hot Springs Campus beginning in 1996

Updated 8/11/2014

Dates

Programs

All of the programs and services listed below were once provided by the Hot Springs VA Medical Center. The systematic dismantling of the facility started soon after Hot Springs and Ft. Meade were merged.

1995 ****Hot Springs integrated** with Ft. Meade to become Black Hills Health Care System

1996 **Pathology services:** Hot Springs lost histopathology and only pathologist

1996 **1N Intermediate Care Ward:** abruptly closed, despite its VA nationally recognized innovative multi- discipline team provision of care for the homeless and inclusion of hospice and respite care

1998 **Podiatry:** lost 2nd podiatrist, podiatric surgery, and residency program at Hot Springs

2000 **Cardiology clinic:** discontinued at Hot Springs

2001 ****Threat of Surgery closure:** averted when SD Sen. Tom Daschle, Senate Majority Leader came to Hot Springs to prevent closure of Surgery at Hot Springs campus

2004 ****CARES Commission** recommended Hot Springs retain its current mission

2006 **Veterans' travel:** Hot Springs no longer providing lodging, meals or plane tickets for referred

2007	Emergency Room: became Urgent Care, with diversion of ambulance conveyance of veterans to other hospitals. Subsequently began utilizing mid-level providers instead of physicians in the area
2007	ICU: discontinued, with integration of all patients and nursing care on same general ward
2009	Routine Ultrasound: discontinued when Hot Springs ultrasound tech retired and was not replaced
2010	Orthopedic surgery: discontinued at Hot Springs
2011	Colonoscopy and upper gastrointestinal endoscopy: discontinued at Hot Springs
2011	Otolaryngology (ENT) clinic: discontinued at Hot Springs
2011	Neurology clinic: discontinued at Hot Springs
2011	General surgery and anesthesia services: discontinued at Hot Springs
2012	Fluoroscopy and other vital on-site radiologist-guided examinations/supervision/consultations: discontinued in Hot Springs when longstanding fee-basis radiologist was not renewed in 2011 and only staff radiologist succumbed to long-known terminal illness in 2012, without replacement
2012	Nuclear Medicine: discontinued in Hot Springs after the two nuclear medicine techs retired and were not replaced
2012	Cardiac stress testing: discontinued at Hot Springs
2012	Pulmonary rehab: discontinued at Hot Springs
2012	Decentralized patient scheduling: discontinued at Hot Springs after Imaging receptionist resigned and was not replaced. Formation of a central scheduling department to handle education and scheduling of patients in Imaging (as well as other services) has resulted in implementation of procedures by less knowledgeable staff and diminished quality of service, with as many as 50% of specialty patients arriving for appointments without completion of appropriate preps. Although about half of these patients usually can be worked back into the day's schedule, many exams need to be rescheduled, causing the veteran needless inconvenience, delays and extra expense
2013	Hepatitis C clinic: discontinued at Hot Springs
2013	Ventilation therapy provided by respiratory therapists
2013	Pacemaker clinic: discontinued at Hot Springs without notice, after 170 veteran visits/year.
2013	Cardiac rehab: discontinued at Hot Springs
2014	Sleep studies due to reduced staff
2014	Cataract surgery: discontinued at Hot Springs
2014	Kinesiology services: discontinued at Hot Springs, following retirement and non-replacement of kinesiologist
2014	OEF/OIF specialist: discontinued at Hot Springs
2014	Prostate biopsies: discontinued in Hot Springs when equipment not repaired. Other than simple cystoscopy, other urologic procedures already had been discontinued in previous years.
**	KEY EVENTS

NOTE:	Loss of these services has resulted in idleness of expensive equipment, extra non-reimbursed patient travel and inconvenience, outsourcing of many studies, increased patient waiting times for appointments, delays in diagnosis, and/or need for less-preferred alternative exams.	
ALSO:	There have been many losses in Hot Springs VA personnel since 1996, as outlined below. Among them--and in addition to those already mentioned along with the above-indicated discontinued services--are numerous other key Hot Springs positions which have been eliminated or significantly modified since Integration with the Fort Meade VA, resulting in compromise of optimal management and delivery of health care at the Hot Springs VA. Some of these lost critical positions include the following: full-time on-site Hot Springs VA Medical Center Director (1996), (physician) Chiefs of Laboratory, Imaging, and Respiratory Therapy (late 1990's), Associate Chief of Staff for Hot Springs (1999), CT Tech (2000's), Pharmacy Secretary (2006), Laboratory Tech (2010), Diagnostic Services Secretary (2011), Diagnostic Services Chief with any prior clinical experience in laboratory, imaging, and/or respiratory therapy (2011), full-time Laboratory Supervisor (2013), and Imaging Supervisor (2014).	
1995	648 Fort Meade Employees	492 Hot Springs Employees
2012	727 Fort Meade Employees	390 Hot Springs Employees
	+79 (Fort Meade Gain)	-102 (Hot Springs Loss)

From the beginning of the process, it was the understanding of the Save the VA Campaign that the Save the VA proposal would be seriously discussed, compared, and contrasted with the original VA proposal. It was also the understanding of the stakeholders attending these meetings that the VA, along with the representatives of the Save the VA group, would participate in a reconfiguration of the original VA proposal for a possible blending of concepts, ideas, and initiatives that were in the best interests of veterans, the communities involved, and the VA system. There was never any dialogue or discussion aimed at finding common ground to better serve our rural veterans. It appears, in retrospect, that VISN 23 management never had any intention of finding common ground with the possibility of modifying their original proposal. In fact, the more research the Save the VA Campaign does, the more it appears the VA Administration has a pattern of making management decisions that have a major effect on the health of veterans without conducting any meaningful analysis. It appears to be only after the fact, when challenged, either by an official investigation or a citizens' group, that an effort is made to construct an analysis that supports the decisions previously made. At Hot Springs VAMC, services have been moved or discontinued despite Secretary Shinseki's assurances this would not happen.

Our veterans, nationwide, answered the call. Now we owe them quality, effective treatment for their medical and mental health needs. They deserve facilities that have a history of meeting those unique needs. They deserve a plan that has been well thought out and anticipates the unique needs of rural veterans, not a document created to support a decision that had already been made with justification created after the fact. The Save the VA Proposal is such a plan. It provides a unique collaboration between the VA and rural communities to ensure quality services for rural veterans now and into the future.

Rebuttal to VA Cost Data and Proposal

Since 1995, services to veterans in the Southern South Dakota, Northern Nebraska and Eastern Wyoming area at the VA Black Hills Health Care System (VA BHHCS) have been systematically cut. This came to a culmination on December 12, 2011, when Janet Murphy, Stephen DiStasio and Dr. Julius came to Hot Springs and told VA employees and the Hot Springs community at an overflow meeting that the VA BHHCS Administration along with VISN 23 would be proposing the closing of the Hot Springs VAMC, building a Community Based Outpatient Clinic (CBOC) in Hot Springs, building a 100 bed Residential Rehabilitation Treatment Program (RRTP) in Rapid City and building a new, larger CBOC in Rapid City. The hospital would not be replaced.

The proposal was presented without any in-depth cost benefit analysis having been conducted. It appears to have been based on meetings within VA management. They simply concluded that services should be moved and eliminated without looking at the data and the practical effect on the veterans whose services would no longer be in Hot Springs.

A community group, calling itself the Save the VA Campaign, began to research the VA Administration proposal. What they found was that the reasons the VA were giving for closure were inaccurate and misleading.

VA Assertion: The number of veterans needing service in this area are projected by the VA to decrease.

Save the VA Response: Based on subsequent FOIA requests, it was revealed that national reports show an increase, not a decrease, in unique count of veterans at the Hot Springs VA by 19% over the last four years.

The American Legion 2012 System Worth Saving Report on Rural Health Care supports these numbers:

"In our findings, we discovered that one out of three veterans enrolled in VA live in rural and highly rural areas. Of the 3.4 million rural veterans enrolled in VA, 2.2 million were treated in 2010. The number of rural and highly rural veterans is expected to increase. Additionally, veterans living in rural areas face many challenges, including the lack of primary/specialty treatment available, difficulty recruiting and retaining VA health-care providers in rural and highly rural areas, and the increased time and distance veterans experience in traveling to VA health-care facilities."

Given the VA management's history of finding data to justify conclusions already reached and the lack of data presented to support projections of a decrease in veterans requesting services, it is difficult to believe that the number of veterans seeking medical services will decrease.

VA Assertion: The Hot Springs VA facility is in poor condition and has outlived its useful life. It is not suitable for modern health care delivery.

Save the VA Response: An onsite inspection by an historical preservation architect, conducted at the request of the Save the VA Campaign and South Dakota Congressional staff, has determined that the HS VAMC facility is in fact in good condition and can be remodeled to meet the needs of current and future veterans well into the future.

This is not the first time that VA management has produced a proposal that lacks substance and supporting documentation. On September 28, 2012, OIG issued an investigative report on the consolidation of the Cleveland Campuses located in Brecksville and Wade Park, Ohio. Many of the deficiencies found in that investigation were also found by the Save the VA Campaign as they investigated the VA proposal for BHHCS. For example the OIG report states:

“Energy: The energy savings found in the documents reviewed was used routinely to address how expensive it was to provide utilities to Brecksville. While there is no doubt that Brecksville was not energy efficient and the heating and cooling systems needed to be updated, we determined that the reported energy costs were significantly overstated. The Director and former Associate Director, who prepared the White Paper, could not provide supporting documentation for the reported \$10 million in annual energy costs at Brecksville. We received data from the Chief of Finance for FY 06 through FY 11 and found that the average utility expenditures over that period were \$3,459,671 annually rather than the \$10 million represented in the presentation. This inflation of energy costs at Brecksville provided misleading information regarding the cost justification of consolidation. The estimated savings is even lower when adjusted to reflect the utility costs incurred to provide the services at other locations.” (page 10)

“Additionally, our document review found a Feasibility Analysis prepared at VA’s request by Basile Baumann Prost & Associates dated May 26, 2005. This analysis stated ‘Currently, Class B office space rents in the market average approximately \$15 per square foot, while Class A rents average over \$21 per square foot.’ The documentation also contained a draft letter dated March 20, 2006, by JLL for the purpose of helping VetDev obtain preferential tax treatment from the City of Cleveland that showed the market rate for Class A office space to be \$23 per square foot. However, by the time the deal was finalized in 2009, JLL advised the final rate of \$48.12 per square foot was a fair price. There is no evidence to support JLL’s determination regarding the reasonableness of the price and when we interviewed the JLL employee he stated that the basis for the statements was that it was new building. It is not clear to us why VA’s consultant, JLL, was allowed to assist VetDev in the EUL process as it appears to be a conflict of interest. The Cleveland Plain Dealer reported that the Mayor of Brecksville stated at the decommissioning ceremony for the Brecksville campus that VetDev had hired JLL to market the property for them.”(page 16)

JLL provided the after-the-fact cost benefit analysis showing that almost any alternative other than renovating the Hot Springs Historic Landmark campus was significantly more cost effective. They also provided the facility comparison between the Save the VA proposal and the VA proposal that found renovation of the facility to be too expensive, despite the fact the current facility was found to be in good condition. JLL seems to have a history of providing analysis that supports local VA proposals.

VA Assertion: Moving to Rapid City provides the veterans with better transportation, education and job opportunities.

Save the VA Response: Veterans themselves say the Hot Springs provides the healing they need away from the noises, stresses and temptations of an urban setting.

The OIG cites the negative impact of moving from a suburban setting to an urban setting, a problem similar to that proposed by moving the Residential Treatment facility in Hot Springs from a rural to an urban setting. In the Cleveland case this move was already resulting in a negative impact on veterans in treatment.

“The Brecksville campus afforded patients more recreation options such as basketball, swimming, and park setting for walking in a suburban area that was free from distractions and temptations. The environment in Wade Park is dramatically different because of the urban setting. There are little to no recreational options and there are no grounds available to the residents to use that are free from negative environmental factors. Residents are often dealing with substance abuse issues and the Wade Park facility is close to areas that afford the opportunity to obtain drugs and alcohol. VA officials noted a decrease in participation in voluntary support meetings that are available to the residents.” (Page 29)

Safety is a major issue for veterans in treatment. The crime index in Hot Springs is 411 compared to 2,408 in Rapid City.

VA Assertion: Contracting with private providers will provide services to veterans closer to home.

Save the VA Response: The region covered by HS VAMC is a medically underserved area and private providers are not experienced in the unique medical and mental health issues of veterans.

While Save the VA agrees that veterans need to have services available as close to where they live as possible, the VA BHHCS’ solution will not accomplish that. The area served by HS VAMC is rural and highly rural. This means that there are currently insufficient resources to serve the population currently requiring medical services in this area. The following counties in the Hot Springs catchment area are designated as Health Professional Shortage Areas:

- South Dakota: Fall River, Custer, Shannon, Todd, Jackson, Mellette and Bennett;
- Nebraska: Sioux, Dawes, Sheridan, Brown, Grant, Cherry, Box Butte, Morrill;
- Wyoming: Niobrara, Crook and Weston.

Adding additional customers to a system already stretched to provide for their current customers does not serve our veterans or the community well. In addition, Dr. Kenneth Kizer, former Under Secretary for Health for the VA, helped shift VA from a hospital-based system to a community-based outpatient clinic (CBOC) in order to move VA care closer to veterans’ homes but then realized that there were problems with non VA primary care providers’ lack of familiarity with VA specific health issues. In an article published in the Journal of American Medical Association in February 2012, Dr. Kizer stated, “Physicians in private practice may not be prepared to treat conditions prevalent among veterans – for example, the Reaching Rural Veterans Initiative in Pennsylvania found that primary care clinicians lacked knowledge of PTSD, and other mental health disorders prevalent among veterans, and were unfamiliar with VA treatment resources for such conditions.”

According to a September 14, 2012 OIG report to a Congressional Sub Committee there are issues with non VA providers, also referred to as fee basis providers, understanding the unique mental health and medical problems of veterans: “Over the past 3 years, the OIG has issued seven reports on VA’s fee care program. Our audits and reviews of fee care have identified significant weaknesses and inefficiencies. Specifically, we found that VA had not established effective policies and procedures to oversee and monitor services provided by non-VA providers to ensure they are necessary, timely, high quality, and properly contracted and billed.”

Additionally the report stated:

“While purchasing health care services from non-VA providers may afford VHA flexibility in terms of expanded access to care and services that are not readily available at VAMCs, it also poses a significant risk to VA when adequate controls are not in place. Although the Under Secretary for Health agreed to our recommendations and provided implementation plans to correct identified issues, VHA still faces major challenges managing the fee care program. Improper contracting practices as reported in other OIG reports only highlight our concerns that VA must ensure proper controls are implemented and monitored before, during, and after contracts are awarded...”

The Nebraska Grand Island VA, a VISN 23 hospital, is an example of how this all plays out for veterans. A number of years ago, the VA hospital there was closed and contracts with local private providers entered into to provide veterans with care closer to home. After several years, these contracts were not renewed and now veterans must travel to Omaha, NE, to receive their care. This is an additional two plus hours drive from Grand Island. This results in longer travel times for the veteran and also means significant added expense for the veteran and their families. If a veteran becomes hospitalized far from home, friends and relatives are less likely to be able to visit, hindering the recovery of the veteran.

The first time the Hot Springs Fall River Hospital board members were made aware their hospital was being considered as an option in the VA’s proposal was at the December 12 public presentation of the VA proposal. The contents of the proposal presented by local VA and VISN leadership came as a surprise to the board of directors of Fall River Health Services (FRHS) despite the fact the VA chose to publicly suggest some type of collaboration with FRHS. The FRHS board has consistently stated publically they do not have the capacity to serve local veterans currently served by the VA.

VA Assertion: Native American Veterans living on reservations near Indian Health Services (IHS) could receive their services through IHS.

Save the VA Response: The local IHS is overwhelmed and the quality of the services is questionable.

All veterans deserve quality health care provided in a timely manner. This includes Native American veterans. The VISN 23 management team has suggested IHS Aberdeen area, which includes Pine Ridge and Rosebud, as a viable provider despite a United States Senate Committee on Indian Affairs investigative report completed December 28, 2010, that states the following:

Through the investigation the Chairman identified certain at-risk facilities given the information that IHS submitted. Specifically, the investigation revealed that IHS hospitals located at Pine Ridge Service Unit, Rosebud Service Unit, Belcourt Service Unit, Rapid City Service Unit, Fort Yates Service Unit, and Winnebago Service Unit had substantial accreditation and EMTALA issues. For instance, a CMS report from March 19, 2010, notes that Pine Ridge Hospital received a number of EMTALA complaints in 2009 and 2010, which centered on insufficient care in its Emergency Department. In addition, in November 2010, CMS reviewed Rapid City IHS Hospital’s corrective action plans in response to a May 2005 EMTALA complaint (fifth revisit) and a September 2008 EMTALA complaint (second revisit). CMS determined that the Hospital’s corrective action plans were unacceptable, requiring the facility to submit more responsive plans in order to avoid jeopardizing its accreditation. (page 23)

The EMTALA refers to the Emergency Medical Treatment and Active Labor Act. The majority of Native American veterans currently served by the Hot Springs VAMC live in the IHS Pine Ridge, Rosebud and Rapid City service areas. Not only does the Senate Committee have issues with the quality of services provided at these facilities, many of the Native American veterans currently served by the VA refuse to go to these facilities due to the poor service. If a Native American veteran seeks treatment at one of these facilities they are routinely turned away and told to go to the VA.

VA Assertion: The VA Administration sought additional input and recommendations from the public.

Save the VA Response: An innovative proposal was produced by the Save the VA Campaign, none of which was included in the VA proposal.

The Save the VA Campaign proposal creates a community/VA partnership that provides a continuum of care from assessment to successful reintegration into the community. This partnership provides for a reinvestment of profits into veterans care while ensuring quality medical services continue to be available for rural veterans.

This proposal addresses two major challenges currently facing the VA:

- How best to provide quality medical care to rural and highly rural veterans close to their homes.
- How to provide treatment for substance abuse, PTSD and homelessness for both older veterans and those returning from recent conflicts in the Middle East.

These challenges are addressed in the Save the VA proposal by:

- Creating a not-for-profit corporation along with a for-profit Veterans Industries Company.
- Reinvesting a portion of the profits into the VA to offset cost of care.
- Training veterans in skills that can be translated into careers.
- Providing education that prepares veterans and community members to participate in the job market of the present and future.
- Providing high quality medical services to veterans in rural areas.
- Constructing more flexible treatment plans to meet the needs of individual veterans.
- Providing a tranquil setting where temptations are minimized and healing is maximized.

In July of 2012, the Save the VA Campaign, staff from the SD Congressional Delegations' Rapid City Offices, representatives of a number of Veterans' Service Organizations, other interested stakeholders, staff from the Nebraska and Wyoming Congressional Delegations' offices by phone and the VISN 23 staff began a series of meetings to discuss the Save the VA proposal. At the first of these meetings, Save the VA made it clear their purpose in participating in these meetings was to determine which of the following might be possible: the VA and Save the VA would agree on a blended joint recommendation to be sent to the Secretary; a partial joint proposal with unagreed upon elements taken separately to the Secretary; or a joint proposal was not possible and each plan would be presented separately.

After four lengthy meetings, on September 10th, 2012, VISN 23 management stated they did not have the authority to discuss the proposal or try to reach common ground. This despite an email sent to VA Black Hills Health Care employees by BHHCS management on August 31, 2012, containing the following paragraph:

“With the completion of the operating and capital costs analyses (sic) and stakeholders meetings approaching it will soon be time to rewrite the proposal into

a recommendation to be forwarded to VA Central Office. The recommendation will likely be forwarded in September. We do not know at this time when we can expect a decision.”

Given the BHHCS’ request for input from veterans, local communities, Native Americans, the Save the VA Campaign and other stakeholders, the expectation was they would revise their proposal to incorporate some of these recommendations. A more serious level of discussion and negotiation was anticipated. Sadly, that never happened.

VA Assertion: It is too costly to renovate the HS VAMC facility.

Save the VA Response: The buildings are in good condition and can be cost effectively renovated.

After a January 2012 request from the SD Congressional Delegation, in June, 2012, VA BHHCS finally produced an analysis of the cost to build a new CBOC in Hot Springs and another in Rapid City along with a new RRTP in Rapid City versus renovation of the current Historical Landmark campus which has served veterans since 1907. The financial consultant providing this analysis was JLL, the same JLL involved in the justification of the Cleveland consolidation. No one from JLL made a site visit of the Hot Springs campus to support this initial assessment. Not surprisingly, the results of this analysis supported the VA BHHCS plan.

In August the VISN 23 staff, in coordination with JLL, completed another analysis of cost to implement the Save the VA proposal including operational costs as well as remodeling costs of the existing facility. Once again both were exorbitant. The 30 year costs to mothball the HS VAMC were \$22,392,147. Given the square footage, this would have been \$1.65 per square foot per year. In fact, Secretary Shinseki, in his letter to the South Dakota Congressional Delegation of March 8, 2012, stated “VA’s assigned cost to maintain an unused building is an estimated \$5.33 per square foot per year, according to the VA Central Office Cost Guide”. This would be a total of \$2,398,500 per year for 450,000 square feet or \$71,955,000 for 30 years not including inflation. In other words the costs were less than a third of what they should have been according to the VA’s own guidelines. If an inflation factor of 2.5 percent per year is used, the total cost over 30 years would be \$106,000,000. What other numbers have been similarly under or overinflated to justify this decision?

Despite the fact the only additional services proposed were to increase the RRTP capacity from 100 to 200 beds by remodeling existing buildings, the proposed staff was 633. The staffing at Hot Springs has never been this high. In fact, the highest staffing level at HS VAMC was less than 500 in 1995 when the Hot Springs facility was administratively merged with the Ft. Meade facility. Current staffing is less than 375. The cost of renovating the Hot Springs facility was also extremely high, proposing the building of a new 84,000 sq. foot building to accommodate the 82 veterans’ treatment beds that did not fit in the current RRTP remodel. There was no discussion about the assumptions made in deciding the current facility would only accommodate 110 veterans and no discussion about what other existing buildings could be used to provide housing/meeting rooms. It was never the intention of the Save the VA Campaign to build an 84,000 square foot building or to increase the staff to 633. In all the meetings held, there was never any dialogue about the best way to provide services to the veterans living in this highly rural area or how to best utilize the beautiful and historic facility to continue a long history of providing quality care to our veterans.

VA Assertion: Due to the decrease in patient numbers, quality of care is a concern.

Save the VA Response: The HS VAMC has a long history of meeting and exceeding quality standards.

The HS VAMC has a long history of providing high quality services as reflected in the CARES, Joint Commission and other accreditation standards met and exceeded, as well as the consistently high satisfaction of the veterans served. The most recent such review found the following as reported by the Rapid City Journal October 1, 2012:

“VA Black Hills Health Care System’s (BHHCS) Mental Health Service was awarded full accreditation by the Commission on Accreditation for Rehabilitation Facilities (CARF) for its residential and outpatient programs related to homeless services, employment services, addictions treatment and PTSD programming. The accreditation is for a three-year period, May 2012-2015.”

“This is the fifth time Mental Health Services has been awarded CARF certification for Residential Programming. In keeping with VA’s desire to demonstrate their commitment to quality of care, the Homeless Programs and Compensated Work Therapy Programs were reviewed and accredited for the first time. Not only did these programs pass the survey with no noted deficiencies, several best practices were noted.”

Veterans want continued services at the Hot Springs VA. They like the way they are treated, the location and the historic building and setting. Native American veterans have signed resolutions supporting continuing to provide the services at the HS VAMC at the same levels as they have been in the past. Veterans specifically state they like the following:

- The wide variety of services provided at the HS VAMC provides for treatment of the entire person.
- Being able to schedule several appointments in one day.
- Being able to walk to all points in town for shopping and work.
- All the recreational activities that are readily available.
- The therapeutic, non-stressful, safe and spiritual environment conducive to healing that the campus provides.
- The historical connection with those who have been healed here and those who have supported that healing over the past 100 plus years.

A representative veteran’s comment is:

“When I went to Vietnam I believed in the cause. I thought that communism would spread like the domino effect and I wanted to do my part to prevent that from happening. Six months into it I began to realize that it was a lost cause. They were a third world country and couldn't, and, at times, wouldn't defend themselves. It's a tall order to go from a peasant country to a democracy. From that time on I was looking forward to getting out of the service, but I had a personal sense of responsibility and I had made a promise to my country. Now my country is breaking their promise to us.”

Fred Smith, Hot Springs, Marine Corp Veteran

And from a clinical psychologist:

“Living with the physical and emotional trauma each day due to their service to our country has already compromised their functioning. Closing the BHHCS will only increase their stress..... The bottom line is this: Diminish the quality of their care - increase the COSTS of their care!!!!”

Janis A. Di Ciacco, Ph.D Clinical Psychologist Denver, CO

Following is a table of the programs and services listing availability of the service and staffing levels on April 5, 2012 and July 31, 2014 at Fall River Hospital (FRHS) and the Hot Springs VA (HSVA).

FRHS-4/5/12	HSVA-4/5/12	SERVICE/PROGRAM	FRHS-7/31/14	HSVA-7/31/14
Accreditation/Quality of Care				
No	No (after certif nurses retired about 2010)	AORN (Association of periOperative Nurses)	No	No (after certified nurses retired about 2010)
No	Yes	CAP (College of American Pathologists)	No	Yes
No	Yes	CARF (Commission on Accredited of Rehabilitation Facilities)	No	Yes
No	Yes	JCAHO (Jt Commiss on Accred of Healthcare Organizations)	No	Yes
Service-Connected Services				
No	Yes	Compensation & pension evaluations	No	Yes
No	Yes	Environmental agent registry exams	No	Yes
No	Yes	OEF/OIF(Op Endur Freedom/Op Iraqi Freedom) specialist	No	No (stopped coming in 2014)
Dental Services				
No	Yes	Dentistry	No	Yes
Diagnostic Services				
Yes	Yes	Laboratory	Yes	Yes
Yes	Yes	Computed tomography	Yes	Yes
No	Yes (weekly)	Echocardiography	Yes (weekly by contract)	Yes (weekly)
No	Yes	Fluoroscopy	No	No (discontinued in 2012)
Yes (weekly by contract)	Yes (weekly)	Magnetic Resonance Imaging (MRI)	Yes (weekly by contract)	Yes (weekly)
No	Yes	Nuclear medicine	No	No (discontinued in 2012)
Yes	Yes	Radiology	Yes	Yes
Yes (regularly scheduled--contract)	No (discontinued about 2009)	Screening mammography	No	No (discontinued about 2009)
Yes	Yes	Teleradiology	Yes	Yes
Yes	No (discontinued in 2009)	Ultrasound	Yes	No (discontinued in 2009)

FRHS-4/5/12	HSVA-4/5/12	SERVICE/PROGRAM	FRHS-7/31/14	HSVA-7/31/14
Dietary Services				
Yes (contract with VA)	Yes (including telehealth)	Clinical dietitians	Yes (contract with VA)	Yes (including telehealth)
Yes	Yes	Food services	Yes	Yes
Emergency/Urgent Services				
Yes (24/7 physician coverage)	No (downgraded to UC* in 2007)	Emergency Room	Yes (24/7 physician coverage)	No (downgraded to UC in 2007)
No	Yes (24/7 physician coverage)	Urgent Care	No	Yes (changed to some PA cov.)
Inpatient/Resident Services				
Yes	Yes	Acute beds	Yes	Yes
No	Yes	Hospice beds	No	Yes
No	No (discontinued in 2007)	Intensive care unit	No	No (discontinued in 2007)
Yes	Yes	Long-term beds	Yes	Yes
Mental Health Services				
No	Yes	Psychiatry	No	Yes
No	Yes	Psychology	No	Yes
No	Yes	PTSD** treatment program	No	Yes
No	Yes	Subst. abuse treatment program	No	Yes
No	Yes	Suicide prevention program	No	Yes
**Post traumatic stress disorder		*Urgent Care		
Pharmacy				
Yes	Yes	Pharmacy	Yes	Yes
No	Yes	Pharmacy anticoagulation clinic	No	Yes
No	Yes	Pharmacy diabetes control clinic	No	Yes
No	Yes	Pharmacy lipid treatment clinic	No	Yes
Primary Care				
Yes	Yes	Physician/mid-level provider clinics	Yes	Yes

Safety/Security

Local volunteer fire fighters only	Yes (24/7 VA Fire Department)	Fire protection	Local volunteer fire fighters only	Yes (24/7 VA Fire Department)
Local public law enforcement only	Yes (24/7 VA Police Dept.)	Security/police protection	Local public law enforcement only	Yes (24/7 VA Police Dept.)

Same Day Surgery

Yes	No (CRNA***services stopped in 2011)	Anesthesia	Yes	No (after discontinuing in 2011)
Yes	No (discontinued about 2011)	Endoscopy	Yes	No (discontinued about 2011)
No	Yes	Cystoscopy	No	Yes
Yes	No (discontinued about 2011)	General surgery same day surgery	Yes	No (discontinued in 2011)
Yes	Yes	Ophthalmologic surgery	Yes	No (discontinued in 2014)
Yes	No (discontinued about 2010)	Orthopedic surgery	No	No (discontinued about 2010)
Yes	No (discontinued in 1998)	Podiatric surgery	Yes	No (discontinued in 1998)
No	Yes	Prostate biopsy	No	No (equipment down in 2014)

Specialty Clinics

No	Yes	Audiology	Yes	Yes
Yes	No (discontinued before 2000)	Cardiology	Yes	No (discontinued before 2000)
No	Yes (mid-level)	Dermatology	No	Yes (mid-level)
Yes	Yes	General surgery	Yes	Yes
No	Yes	Hepatitis C	No	No (discontinued in 2013)
No	Yes	Nephrology	No	Yes
Yes	No (discontinued about 2011)	Neurology	Yes	No (discontinued about 2011)
No	Yes	Ophthalmology	No	Yes
No	Yes	Optometry	No	Yes
Yes (physician)	Yes (with PA**** after approx 2011)	Orthopedic	Yes (physician)	Yes (with PA after approx 2011)
No	No (discontinued about 2011)	Otolaryngology (ENT)	No	No (discontinued about 2011)
Yes	Yes	Podiatry	Yes	Yes
No	Yes	Psychology	No	Yes
No	Yes	Urology	No	Yes

FRHS-4/5/12	HSVA-4/5/12	SERVICE/PROGRAM	FRHS-7/31/14	HSVA-7/31/14
Therapeutic Services/Supplies				
Yes	Yes	Cardiac rehabilitation	No	No (discontinued in 2013)
Yes (equip available by delivery)	Yes	CPAP (Continuous Positive Airway Pressure)	Yes (available by delivery)	Yes
No	Yes	Home-based primary care program	No	Yes
Yes (equip available by delivery)	Yes	Home oxygen	Yes (available by delivery)	Yes
No	Yes	Kinesiotherapy	No	No (discontinued in 2014)
Yes	Yes	Occupational therapy	Yes (contract)	Yes
Yes	Yes	Physical therapy	Yes	Yes
No	Yes	Prosthetics	No	Yes
****Physician assistant		***Certified registered nurse anesthetist		
Yes	Yes	Pulmonary rehabilitation	No	No (discontinued in 2012)
Yes	Yes	Recreation therapy/activities	Yes	Yes
Yes	Yes	Respiratory therapy	Yes	Yes
Yes (contract)	Yes	Speech lang. pathology/therapy	Yes (contract)	Yes
Other Services				
No	Yes	Cardiac pacemaker monitoring/mgt	No	No (discontinued in 2013)
No	Yes	Chronic disease management	No	Yes
No	Yes	Dialysis	No	Yes
No	Yes	Drug and alcohol detoxification	No	Yes
No	Yes	Medical library	No	Yes
No	Yes	Nuclear cardiac stress testing	No	No (discontinued in 2012)
Yes	Yes	Outpatient telemetry	Yes	Yes
Yes	Yes	Sleep studies	Yes	Yes
Yes (wkly, as needed, by contract)	Yes	Social work services	Yes (wkly, as needed, by contract)	Yes
No	Yes	Staff education department	No	Yes
No	Yes	Telemedicine	No	Yes

FRHS-4/5/12	HSVA-4/5/12	KEY PERSONNEL	FRHS-7/31/14	HSVA-7/31/14
Diagnostic Services				
5-FT (Full-time) (24/7 avail)	5-FT (24/7 avail) (1 lost in 2010)	Laboratory techs	5-FT (24/7 avail)	5-FT (24/7 avail) (1 lost in 2014)
0	0 (1 eliminated in 1998)	Pathologist	0	0 (the only1 eliminated in 1998)
0	1-FT	Phlebotomist	0	1-FT
0	1-PT (Part-time) (weekly)	Echocardiographer	1-PT (weekly by contract)	1-PT (weekly)
0	2-FT	Nuclear medicine technologists	0	0 (2 retirees not replaced 2014)
3-FT (24/7 availability)	4-FT (24/7) (1 retiree not replaced)	Radiologic technologists	3-FT (24/7 availability)	3-FT (24/7) (retiree not replaced 2014)
0	1-FT	Radiologist	0	0 (deceased not replaced 2012)
1-FT (daytime)	0 (retiree not replaced 2009)	Ultrasonographer	1-FT (daytime)	0 (retiree not replaced 2009)
Dietary Services				
1-PT (contract with VA)	4-FT (including telehealth)	Clinical dietitians	1-PT (contract with VA)	4-FT (including telehealth)
Emergency/Urgent Services				
1-(24/7 physician coverage)	0 (downgraded from ER 2007)	Emergency Room Providers	1-(24/7 physician coverage)	0 (downgraded from ER 2007)
0	1-(24/7 physician coverage)	Urgent Care Providers	0	1-PA in day; 1-physician@PM)
Mental Health Services				
0	2-FT (Domiciliary)	Psychiatrists	0	1-FT (Dom) (reduced since 2012)
0	2-FT (Dom);1-FT (clinic)	Psychologists	0	1-FT (Dom);1-FT (clinic)(down 1)
Pharmacy				
2-FT	8-FT (including 1 contract)	Pharmacists	2-FT	5.4-FT (fewer empl/cancelled contract)
0	1-FT	Pharmacy technicians (call center)	0	4.5-FT (more facilities covered)
2-FT	6-FT	Pharmacy technicians (outpatient)	3-FT	5-FT (realignment)

FRHS-4/5/12	HSVA-4/5/12	KEY PERSONNEL	FRHS-7/31/14	HSVA-7/31/14
Primary Care				
included with mid-levels below	included with mid-levels below	Clinic nurse practitioners	included with mid-levels below	included with mid-levels below
2-FT family practitioners	2-FT family practitioners	Clinic physicians	1-FT family practitioner	2-FT family practitioners
1-FT	2-FT (clinic);2-FT (Dom)	Mid-level providers	3-FT	2-FT (clinic);3-FT (Dom&UC)
included with mid-levels above	included with mid-levels above	Physician assistants	included with mid-levels above	included with mid-levels above
Same Day Surgery				
1-scheduled for surgeries	0 (discontinued about 2011)	Certified registered nurse anesthetist	1-scheduled for surgeries	0 (discontinued about 2011)
1-scheduled for endoscopies	0 (discontinued about 2011)	Endoscopist	1-scheduled for endoscopies	0 (discontinued about 2011)
1-scheduled for surgeries	0 (discontinued about 2011)	Operating general surgeon	1-scheduled for surgeries	0 (discontinued about 2011)
1-scheduled for surgeries	1-scheduled for surgeries	Ophthalmologic surgeon	1-scheduled for surgeries	0 (discontinued in 2014)
1-scheduled for surgeries	0 (discontinued about 2010)	Orthopedic surgeon	0	0 (discontinued about 2010)
1-available for surgeries	0 (discontinued in 1998)	Podiatric surgeon	1-available for surgeries	0 (discontinued in 1998)
0	1-for cystoscopy & prostate bx	Urologist	0	1-cystoscopy but no prostate bx

FRHS-4/5/12	HSVA-4/5/12	KEY PERSONNEL	FRHS-7/31/14	HSVA-7/31/14
Specialty Clinics				
0	1-PT (2 days/wk)	Audiologist	1-irregularly scheduled	1-PT (being recruited)
1-regularly scheduled	0 (discontinued before 2000)	Clinic consulting cardiologist	1-regularly scheduled	0 (discontinued before 2000)
1-regularly scheduled	1-regularly scheduled	Clinic consulting neurologist	1-regularly scheduled	0 (discontinued about 2012)
0	1-regularly scheduled	Clinic consulting ophthalmologist	0	1-regularly scheduled
1-regularly scheduled	1-reg sched (PA rather than MD)	Clinic consulting orthopedist	1-regularly scheduled	1-reg sched (PA rather than MD)
1-regularly scheduled	1-regularly scheduled	Clinic general surgeon	1-regularly scheduled	1-regularly scheduled
1-regularly scheduled	1-FT (decreased by 1 in 1998)	Podiatrist	1-regularly scheduled	1-FT (decreased by 1 in 1998)
Therapeutic Services & Supplies				
1-FT	1-FT	Activities/recreation assistant	0	1-FT (currently unfilled)
1-FT	1-FT	Activities/recreation director	1-FT	1-FT
0	1-FT	Kinesiotherapist	0	0 (retiree not replaced 2014)
1-PT	1-PT (2 days/wk)	Occupational therapist	1-PT (contract)	1-PT (3 days/wk)
2-FT, 2 PT contract	1-FT	Physical therapist	4-FT	2-FT
1-FT, 1-PT contract	1-FT	Physical therapy asst/health tech	1-FT	1-FT
1-FT,2-PT(daytime w/occ. call-back)	6-FT (24/7 avail)	Respiratory therapists	3-FT, 1-PT (daytime)	6-FT (24/7 avail)
1-PT (contract)	1-PT	Speech/lang. path. (SLP)/therapist	1-PT (contract)	1-PT