

**U.S. Department of Veterans Affairs
Capital Asset Realignment for Enhanced Services (CARES) Commission**

August 6-7, 2003
Crystal City, Virginia

Commissioners in Attendance:

The Honorable Everett Alvarez, Jr., Chairman
Charles Battaglia
Joseph E. Binard, MD
Chad Colley
Vernice Ferguson, RNB, M.A.
John Kendall, MD, Vice Chairman
Richard McCormick, PhD
Layton McCurdy, MD
Richard Pell, Jr.
Robert A. Ray
Sister Patricia Vandenberg, CSC
The Honorable Raymond John Vogel
The Honorable Jo Ann Webb, RN
Michael K. Wyrick, Major General, USAF (Ret.)
Al Zamberlan

Wednesday, August 6, 2003

Chairman Alvarez opened the meeting at 8:30 a.m. He said the Commission has a lot of material to cover during the meeting. Today's session (August 6) will be open to the public all day. Tomorrow's session (August 7) will be open in the morning but not in the afternoon when the session will cover administrative and logistical matters.

The Chairman introduced the first item on the agenda: the Commission's assessment of the VHA health care enrollment and expenditure model.

**Presentation By
Dr. Robert Burke
The George Washington University**

Dr. Burke said he was making this presentation on behalf of his two colleagues who, while unable to attend the session, were also responsible for the work. He said work activities included reviewing voluminous materials, meetings with the National CARES Program Office staff and clarification sessions with Milliman in addition to analysis. Findings were presented to the Commission earlier at the May meeting. The team also has briefed the VA Senior Resource Group and Secretary Principi. Overall findings include:

- The Milliman model is a *reasonable* analytic approach to estimating VA enrollment, health care utilization and expenditures.
- Additional sensitivity analysis of the model's enrollment results would be useful to both the Commission and CARES and was recommended.

Dr. Burke understands the model is currently being updated to incorporate the recommended changes. However, the timing of the revision – now scheduled for August 15 -- could be a problem in view of the Commission's schedule. The issue is whether there will be significant changes in the Planning Initiatives as a result of the revision and whether the Commission will have to deal with these while it is in the field holding hearings.

Dr. Burke noted the team's definition of "reasonable" meant that the model was:

- Logical – internally consistent and coherent.
- Auditable – outside analysts can look at it and figure out how it works.
- Comparable – data and methods are consistent with standard practices.
- Defendable, in view of available alternatives.
- Robust, given the uncertainty of future circumstances.
- Timely – applicable to the current environment.
- Verified and validated – was tested to ensure that results were not skewed.

The team looked at three different uses of the model: enrollment forecasting, health care utilization and unit cost projection. With regard to *enrollment*, the team's assessment was that the model uses a reasonable approach. The main concern is that the assumptions about veteran migration that are used in forecasting veteran population are not used for enrollment modeling. Another concern is that the model uses fixed enrollment rates. Also, the model uses enrollment data from a 13-month period (April 2000-April 2001) but data for 30 months are now available and should be used. A final concern is with the market share caps built into the model for both CARES and enrollment level decision analysis.

With regard to *utilization*, the team's assessment was also that the modeling approach was generally sound. The approach compared survey data for the VA's 65 and over population to Medicare data in order to validate the survey responses. VA then assumed that the survey data for the under-65 population would be valid because the 65 and over data were valid. The Commission's assessment team wanted Milliman to compare VA survey data with private sector data for the under-65 population. However, this was not done. The assessment team was also concerned that the model did not give VA credit for its superior technology and IT infrastructure.

In the area of *unit costs*, the team again found that the model's approach was sound for purposes of CARES. Initially, there were concerns that NCPO was using Cost Distribution Reports (CDR) instead of unit cost information from the Decision Support System (DSS). However, this concern has been addressed and CARES is using DSS unit costs. CARES is also using data that make its unit costs more comparable to Medicare unit costs.

Dr. Burke emphasized that modeling for CARES is different from modeling for Enrollment Level Decision Analysis (ELDA), although the CARES model is built on ELDA. The ELDA process is a *policy analysis* tool useful for short-term enrollment forecasting. It focuses on the time period one-to-two years out and assumes the maximum demand. It is revised and updated every twelve months for decision making. The CARES model is a *planning* tool that attempts to

forecast imbalances in supply and demand in the very long term: ten-to-twenty years out. Its purpose is to inform long lead-time investment decisions.

Dr. Burke said a process is now underway in VHA to enhance and improve the model that was used to develop the Planning Initiatives (PIs) for this round of CARES. Presumably, the CARES Office and Milliman is incorporating the suggestions the Commission's assessment team made in its May 2003 report, including allowing for geographic migration of the veteran population and using 30 months worth of data instead of only 13 months. The revisions to the CARES model are scheduled for completion by August 15; the Commission's team has not yet seen a report on the changes.

Because the model will be used as the basis for making very substantial investment decisions for a long period of time, the Commission's assessment team (Dr. Burke et al) believes that CARES needs to "get it right the first time." To do this, two actions should be taken. One action is to deal with the 25 percent market share threshold that the CARES process built into the model. The assessment team believes that is not sufficient to deal with future uncertainty. The other action is to conduct the recommended sensitivity analysis on the current results with regard to enrollment assumptions.

The team also believes that CARES Planning Initiatives and/or market plans should be updated quickly to reflect the results of changes to the model. It further recommends that the Commission focus on the most robust proposals included in the market plans – the proposals most likely to be viable under a wide range of future conditions.

Other team recommendations for Commission consideration include:

- Using one morbidity grouper – to improve coherence and increase integration of the budget development and budget allocation processes.
- Finding ways to incorporate VA's medical management and information technology infrastructure advantages into the model's efficient ratings.
- Developing a better understanding within the VA about how the ELDA and CARES models really work and about their specific uses.
- Finding better ways to explain the modeling capability and expanding the pool of knowledge about the model on a VA-wide basis.
- VA needs to improve its configuration management of the model, especially in regard to documenting changes to data and decision rules.

Q&A/Discussion

A Commissioner expressed concern that the model's projections may not be correct in rural areas, where enrollment rates are already at the 60-70 percent level and also expressed concern about the marketing caps that were imposed as part of the CARES process. He asked Dr. Burke to comment on these two aspects of the model. Dr. Burke agreed with the Commissioner's concerns, especially the marketing caps. He said that CARES marketing was done on a national level for the first go-around. He believes future processes should use regional models.

A second Commissioner asked how the absence of long-term care might impact the model. Dr. Burke replied that the assessment team was asked not to look at that aspect of the model, so he hasn't really thought about the answer in the context of the CARES Commission's task.

Asked whether the CARES/Milliman group was performing the sensitivity analysis that has been recommended, Dr. Burke replied that the Secretary asked Milliman to see whether it could incorporate that in its mid-August report. He said he isn't sure whether or not the sensitivity analysis is being done. Asked how the absence of sensitivity analysis might affect the modeling being done, Dr. Burke answered that it is hard to tell; he hopes Milliman will be able to include it.

Dr. Burke also noted that, at the time of the team's April review, CARES/Milliman had not documented or demonstrated the model's reliability and validity. He said there are several different versions of the model. The assessment team had seen no documentation for why the particular version used was selected.

Another Commissioner expressed the concern that the judgments made about enrollment for the CARES modeling process are "out of whack" and asked if the Commission could conclude that the model is dependable. Dr. Burke replied that the enrollment figures should be okay for the first five years. However, the enrollment numbers for years six through twenty should be fixed based on the sensitivity analysis.

A Commissioner reported that the VISN-level planning people he talked to during the site visits like the model and embrace the concept behind it. Another Commissioner agreed, but noted that the field staff are still concerned about how the model will be used. The model was introduced very quickly and people have not had a chance to get the in-depth understanding that will be needed for implementation.

Discussion of Possible Impact of Model Revisions on the Commission's Processes

Chairman Alvarez asked Dr. Burke whether the Commission could look forward to a fast fix that could be used in the planning process. Dr. Burke said some of the model's basic components need to be realigned and fixed first. After that, other people could learn to run the model without requiring a lot of time. Dr. Burke added it would be interesting to see what new Planning Initiatives emerge after the improvements are made to the model.

A Commissioner asked whether the market plans would need to be revised as a result of re-doing the model. Dr. Burke's answer was "maybe." The Executive Director observed that the best the Commission can hope for is to have revised information available when it starts its deliberations. New information will *not* be available for the hearings.

Another Commissioner said a document implies changes may be made to the plan while the Commission is holding its hearings. This possibility raises concerns. Such changes may cast doubt on the integrity of the process.

One Commissioner asked Dr. Burke how many of the people he had talked to had front-line hospital management experience. Dr. Burke's answer was one or two people out of a total of six or seven. The Commissioner followed up by noting that the objective is to get health care to patients. The main problem he sees is that of long waiting times. He thinks CARES may have lost sight of the main objective by being too concerned about "crunching numbers."

The Chairman observed that the Commission's job in looking at the realignment of capital assets is to concern itself with objectives such as reducing the waiting times. He believes the down-the-road projections need to be as valid as possible to determine whether today's conditions, such as long waiting times, will persist into the future.

Dr. Burke observed that it will also be important to look at whether events such as changes in Medicare or changes in eligibility would impact the projections and how. He believes that somebody should be working on determining the effects of policy changes. A Commissioner agreed, stating that policy changes will have a big effect on enrollment that could change the picture in regard to capital assets requirements. Another Commissioner made the point that the biggest policy change was the change in eligibility requirements. If there ever was going to be a huge surge in demand for VA beds, it would have happened then. But it didn't occur. Another Commissioner observed that veterans are aware of what's going on in the VA system. If VA doesn't have the facilities, there won't be a surge in demand.

One Commissioner expressed the view that many people would rather have the status quo than make changes. He believes the Commission should be bold. It must be willing to make changes that will benefit everyone in the long term. It is important for the Commission to consider the whole body of VA health care.

A Commissioner asked Dr. Burke whether he and his colleagues basically were trying to validate the projections side of the model. Dr. Burke answered affirmatively. He emphasized that some people hold the view that Milliman has had a long time to work with the model. However, the fact is that Milliman only had about nine months to put together the CARES model. The rest of their experience – about four years – has been working with the ELDA projections. Dr. Burke's opinion is that the February model, while it still needs improvement, was quite good. In response to a Commissioner's question, Dr. Burke said he and his colleagues will continue to review what is now going on with the model and will report to the Commission on changes and improvements.

After the Commission's discussion and general agreement regarding the need for a sensitivity analysis and issue of the model's projections beyond 5 years, Chairman Alvarez said the Commission will be asked to vote on accepting the model later in the session after the Commissioners have had a chance to ask any additional questions they may have.

**Briefing on the Draft National CARES Plan By
Richard Larson, Executive Director and
Commission Professional Staff**

The Chairman announced that the Secretary had released the Draft National CARES Plan on Monday, August 4, 2003, for Commission review. He asked Mr. Larson, the Executive Director, to bring the Commission up to date on activities and events.

Mr. Larson first announced several personnel changes on the Commission staff. Dick Fry has returned to work at VISN level and Calvin Mitchell has been selected into VHA's Associate Director Training Program. New staff members include Johnetta McKinley from the Charleston Office and Sara Lee, with Mental Health care experience. Additionally, Tom Keefe has joined the staff to handle airline reservations and transportation arrangements for the Commission and

Scott Ward will be responsible for receiving, evaluating and categorizing the comments that the Commission receives about the Plan and as a result of the hearings.

Mr. Larson said the staff received a draft copy of the Draft National Plan last Friday, August 1, and have been working with it since then to understand and analyze its contents. The official transmittal was received on Monday and was immediately sent to the Commissioners, some of whom received them in their hotel rooms the previous night. Receipt of the official Draft National Plan moves the Commission into the second stage of its work – conducting public hearings on the Plan.

The rest of the day's meeting was designed to help prepare the Commissioners for the hearings by: (1) informing the Commission about what the Plan contains by topic and merging this with information from the Commission's site visits; and (2) facilitating a dialogue among the Commissioners that will indicate what the main issues are.

Overview

The introductory chapters of the Draft National Plan lay the groundwork for specific proposals by discussing the major developments affecting VA health care management and delivery over the past decade:

- The reinvention of VA health care to focus on outpatient delivery.
- The changing health care needs of veterans.
- VA's emphasis on the quality of health care provided to veterans.
- VA's leadership in health care technology.

The Draft National CARES Plan consists of 20 chapters, organized by CARES categories (access, proximity, small facilities, etc.). There are also six appendixes – A through F -- with Appendix A being an Executive Summary that provides an overview on a VISN-by-VISN basis. The Draft National Plan also emphasizes stakeholder involvement, discussing the processes used to obtain public participation in the planning and detailing outreach to key stakeholder groups, including veterans service organizations, the Congress, affiliates, unions and employees.

In the *small facilities* category, the Draft National Plan identifies nineteen acute care small facilities. Eleven of these facilities will retain acute hospital beds and eight of which will convert acute care beds over the next several years. Of the eleven facilities scheduled to retain acute care beds, seven are proposed for designation as Critical Access Hospitals (CAH). The designation was developed by the CARES program as a way to retain and manage these facilities. VA-wide policies and definitional requirements for Critical Access Hospitals are outlined in the Draft National Plan but are still evolving.

The specific small facilities actions proposed in the Draft National Plan are as follows:

Convert to CAH

Hudson Valley-Castle Point
Altoona
Beckley
Poplar Bluff (already converted)
Cheyenne
Grand Junction
Hot Springs

Convert Beds

Altoona
Knoxville
Kerrville
Butler
Ft. Wayne
Saginaw
Walla Walla
St. Cloud

A Commissioner asked how the CARES Program came up with the definition used for designating certain facilities as “critical access hospitals,” noting that it is difficult to take the designation on faith alone. Another Commissioner observed that Appendix N to the Draft National Plan implies that VA simply used the CMS (Medicare) criteria.

In the *proximity and campus realignment* category, the Draft National Plan identified 19 tertiary and 13 acute care facilities meeting the proximity criteria. The Under Secretary for Health added another related category – campus realignment – during the CARES process. The proposal include:

- Closing two facilities (Pittsburgh-Highland Drive and Gulfport) and transferring the services provided there to nearby facilities.
- Realignment six campuses – Canandaigua, Lexington/Leestown, Brecksville, Marlin, Waco and Livermore. In these cases, some or all of the medical services will be moved to other VA facilities and alternate uses will be sought for the current facilities or they will be closed.
- Converting from 24-hour operations to eight-hour operations at six facilities: Bedford, Montrose, White City, Walla Walla, Knoxville and Kerrville.
- Conducting further studies of possible consolidation, conversion or closure at an additional seven facilities: Manhattan, Vancouver, Montgomery, Lake City, Big Springs, Lexington/Louisville and Augusta Uptown. In all cases, specific recommendations were included in the Draft National Plan. In some cases, studies are to be completed in time for the next VA strategic planning cycle; in other cases, no timetable was specified.

Commission discussion developed information indicating that the term “realignment” can mean either “closure” or “consolidation of services.” The term “next cycle” was not defined in the plan but is taken to mean “over the next several years.” Some Commissioners expressed confusion about the meaning of the different types of actions included in this category; but were assured that additional details would be provided before the hearings and that Commissioners will know the specifics of what is being proposed. One Commissioner asked to have a list of the Under Secretary’s recommendations, VISN-by-VISN, detailing exactly what the Commission is expected to act on. Some Commissioners thought that the Commission might have difficulty supporting some of the recommendations in the Draft National Plan based on what they have seen and heard without having more data.

In regard to *access* recommendations, it was noted that initiatives in this category are based on “travel times” to obtain VA health care. The Draft National Plan identifies:

- 161 new Community-Based Outpatient Clinics (CBOCs) based on access gaps.
- 101 new CBOCs based on workload.

The Plan prioritizes the recommendations to provide a balance between “outpatient access and capacity growth” and “safety and availability of acute inpatient structure.” The prioritization process resulted in 48 new CBOCs being designated as “highest priority” based on large future capacity, large access gaps and a projected enrollment of 7,000 per CBOC. The highest priority new CBOCs would be located in VISNs 1, 6, 7, 8, 16, 20 and 23.

For *outpatient care*, the Draft National Plan notes that between 1996 and 2002, the VA’s average daily census decreased by 53 percent while outpatient visits increased 54 percent and the total number of veterans treated increased by 1.5 million. Through 2009, the CARES model projects a short-term need to expand outpatient care (mostly primary care clinic stops). In the longer term (2010-2022) the demand gradually decreases. The solutions to the short-term increase in demand recommended in the Draft National Plan center around expanding existing CBOCs and opening new CBOCs. However, the Plan also recommends expanding other ways of addressing outpatient care, including telemedicine, contract care and enhancing existing space.

In the category of *inpatient care*, the Draft National Plan identifies 60 planning initiatives, 37 of them resulting from increasing workload. The Plan projects that 90 percent of VA’s inpatient workload will be handled in house by 2022. The investment strategy laid out in the Plan is based on need for inpatient care services as well as on the condition of existing space. No priorities have been established among the initiatives in this category and there is very little to go on.

In regard to *infrastructure*, the Draft National Plan emphasizes that the average age of VA facilities is 50.4 years. The VISNs considered alternatives for dealing with this issue, including new construction, renovation, leasing and enhanced use leasing. The Plan focused on the time period 5-10 years out, not on the full 20-year period. Existing space was scored on a 1-5 scale (with 5 being the best) and any facility scoring “3” or less was considered for inclusion as an initiative. Seismic strengthening projects were given highest priority because of their safety implications. In all, 63 VA sites were put on the priority list for seismic strengthening work with projects totaling over \$440 million.

The Draft National Plan for *Special Disabilities* addresses only “spinal cord injury and disorders” and the “blind rehabilitation” program. Other programs in this category – mental health, homeless and domiciliary and traumatic brain injury – were omitted from the Plan. For the category as a whole, VA lacked comparable private sector data. For blind rehab and spinal cord injury and disorder, alternative data sources and forecasting methods were developed that could be used. Consequently, the Draft National Plan includes:

- Two new Blind Rehabilitation Centers -- in Biloxi and Long Beach.
- Spinal Cord Injury initiatives in nine locations.

For *extended care* (mental health, domiciliary and nursing homes), the forecasting model is being revised for use during the next VA strategic planning cycle with work scheduled for completion in April 2004. In July 2004, the CARES program will be integrated with the VA Office of Planning and Policy. In the meantime, no Planning Initiatives were centrally developed to cover workload gaps. However, VISN did submit capital investment proposals to address poor space conditions. In all, the Draft National Plan includes 12 new extended care construction proposals in nine different VISNs.

Plans for the *future* include:

- Completing the mental health, domiciliary and nursing home care plans by April 2004.
- Integrating CARES with the Office of Planning and Policy in July 2004.
- Prioritizing the capital program.

Small Facilities Overview

The small facilities initiative reviewed facilities with low volume workload and selected surgical procedures, focusing on the facilities' "acute bed" mission (i.e., exclusive of mental health or long-term care).

The objectives of the small facilities initiative are (1) to ensure cost-effective, appropriate high-quality care, (2) evaluate the functioning of small facilities within each market, and (3) assess their role in meeting future projected demand for acute inpatient care. "Quality" was defined as including clinical proficiency, a safe environment and appropriate facilities.

The need to review the role of small facilities as part of the CARES process stems from several factors:

- The emphasis on patient safety, quality and outcomes in acute settings, especially surgical procedures.
- Advances in medical technology (which influence health care).
- The shift to ambulatory care.

Additionally, low workloads and small acute bed sections affect staff proficiency and retention, as well as the quality of care. Capital improvements to maintain these low volume operations are expensive and community-based options are often available. Some VA small facilities have already chosen to close but others, where options are not available, are still trying to meet the needs of the veterans they serve.

The major recommendation in the *small facilities* category included in the Draft National Plan is to designate selected sites as "critical access hospitals (CAH)." The model used in developing the designations recommended in the Plan is based on criteria developed by the U.S. Department of Health and Human Services (HHS), specifically the Centers for Medicare and Medicaid Services (CMS). VA doesn't yet have its own criteria, but it will be developing them at some unspecified time in the future. The CMS criteria -- that were used as a guide for the CARES small facility initiatives -- are:

- A location more than 35 miles from the nearest hospital.
- A facility deemed by the state to be a "necessary provider."
- No more than 15 acute beds (up to 15 beds total, including swing beds).
- Patient length-of-stay duration is less than 96 hours (except for respite/hospice).
- The facility is part of a network of hospitals.
- The facility may use physician extenders (nurse practitioners, physicians assistants or registered nurse midwives) with physicians on call.

The CARES program defined "small facilities" as being those with acute care and acute medicine beds that are projecting less than 40 acute beds for medicine, surgery and psychiatry in 2022. Several other factors were also considered as part of the CARES analysis, such as cost data, patient satisfaction surveys, surgical procedures by volume and type for the past two years,

average bed-day-of-care costs compared to Medicare unit costs, distance to the nearest VA medical facility and literature reviews.

The options available to small facilities during the CARES process were:

- Retain acute hospital beds.
- Close acute hospital beds and reallocate the workload to another VA facility.
- Close acute hospital beds and implement contracting, sharing or joint venturing in the local community.
- Some combination of the above, but primarily focusing on contracting with a community provider or referral to another VA facility.

In all, 19 VA facilities were considered to be *small facilities* under the criteria adopted for CARES. Of these, eleven Medical Centers would retain the acute hospital beds and eight Centers would close acute hospital beds over the next several years. A table included with Tab 3 in the Commission briefing book summarizes the actions recommended for each of twenty-three facilities that were reviewed as part of the CARES process.

At the eleven facilities where acute beds would be retained, the scope of practice would be restricted to limit the number of surgical inpatient beds and Intensive Care Unit (ICU) beds. The Draft National Plan calls for inpatient surgery beds to be converted to observation beds at the following: Hudson Valley/Castle Point, Erie, Beckley, Dublin, Poplar Bluff, Muskogee, Cheyenne, Grand Junction, Des Moines and Hot Springs. Further, seven of the eleven Medical Centers would convert acute beds to the *critical access hospital* model. These are: Hudson Valley/Castle Point, Altoona, Beckley, Poplar Bluff (which is already functioning like a CAH), Cheyenne, Grand Junction and Hot Springs.

The eight facilities that would not retain acute hospital beds and the actions recommended in the Draft National Plan are:

- Altoona – close acute beds after 2012.
- Knoxville – close acute and long-term beds by consolidating Knoxville and Des Moines.
- Kerrville – close acute beds; implementation to be coordinated with San Antonio.
- Butler, Ft. Wayne, Saginaw, Walla Walla and St. Cloud – close through combination of referrals to other VA facilities and community hospitals.
- Big Spring – close inpatient surgery.

The *conclusions* regarding *small facilities* presented in the Draft National Plan are: (1) there is an emphasis on changing from inpatient care to outpatient care; (2) the number of bed days of care in small facilities is declining; (3) acute care in rural areas can best be provided using a Critical Access Hospital-like model; (4) using the CAH model, the scope of practice in small facilities should be restricted to improve efficiency and effectiveness and to enhance their level of functioning within a national health care delivery system; (5) VA policies are needed to develop and implement policies to govern the operation of acute beds in a CAH-like model.

Information about *small facilities* developed during the Commission's site visits noted a mix of urban and rural locations with a variety of travel issues involved. In some locations, clinical providers are not available and the number of contract beds available may be limited or non-existent. Actions to change several small facilities would affect their medical school affiliates; others are impacted by historic designations. In some facilities, VA is the preferred provider for

native-American veterans. Some facilities are well maintained but have no patient activity; others are in poor condition and would not meet JCAHO accreditation requirements.

Q&A/Discussion

A Commissioner began the discussion by asking what was meant in the Plan by “limiting surgery.” The answer provided was that it means different things for different facilities.

Various Commissioners identified and discussed issues associated with the recommended designation of certain facilities as “critical access-like hospitals.” One wanted to know how a VA facility could be operated as a CAH if there are no standards. Another wondered how the various facilities were tested for “CAH-ness” in the absence of standards. A third said the key test is what the plan is for opening *new* VA CAH facilities. He expressed the view that the CAH-like designation was a political solution that was created at the last minute. A Commissioner also wondered whether VA facilities would become CMS Critical Access Hospitals that are open to the public.

Continuing the discussion, a Commissioner observed that in real CAH situations, the designated hospital is the only hospital in that geographic area, which is *not* true of every facility on the VA list (Butler and Altoona, for example). In these instances, a key question is what would be the relationship with community hospitals.

One Commissioner wondered why the Des Moines facility was not being converted to a CAH. Another expressed surprise that Des Moines qualified as a “small facility.” A third Commissioner asked about the Muskogee facility’s designation. In reply, another Member said Muskogee is a fine facility that is underused. But there is no plan to attract veterans from Tulsa or to encourage them to use Muskogee instead of Oklahoma City. Yet another Commissioner said Muskogee would be a very attractive facility to develop because it is new. Prescott was cited as another example of a facility being expanded to relieve pressure on another facility (Phoenix in this case).

Drawing on site visit experience, a Commissioner noted that Poplar Bluff is already functioning as a critical access hospital. The Commissioner noted that Kerrville, which may be phased out over time, is an example of a facility where the CAH criteria don’t really fit. Another Commissioner asked whether Kerrville wasn’t really a holding facility for San Antonio – a place to bring patients back closer to home. In regard to Kerrville, a third Commissioner said the best approach would be to “ramp up” San Antonio as fast as possible because it is too expensive to keep that facility open. He noted that the facility pays for one physician and two RNs every day from 4:00 PM until 6:00 AM just for emergencies.

One Commissioner observed there is a large disparity in the savings that would be generated by the Draft National Plan. Where the Plan proposes to close an entire facility, the savings would be large. However, where the Plan recommends just closing medicine beds, the savings would be much less.

A Commissioner observed that the CAH designation is a quality issue, with the key ICU question being the number of patients and who is being served. Also cited is a need to maintain mental health capacity in some CAH hospitals because there may be no mental health capacity in the community.

Another Commissioner wondered whether the CAH designation solves some problem. He also would like to know what the point is of having observation beds and what they mean.

The Commission also discussed the small facility recommendations in the context of surgery services. One Commissioner reported that no community access is available in Beckley. The VA facility there has only one bed, but it might not make sense to convert the facility to outpatient surgery in view of the community situation. A second Commissioner agreed, saying that he wouldn't want to jeopardize the veteran population. His view is that if there are enough vets in the area to support surgery, the facility should be kept open. A Commissioner said he heard that veterans have unique problems that only VA can handle, but he doesn't know whether or not this is true. Another Commissioner offered the view that volume is important. Patients want to go where there are enough cases of a similar type. A third Commissioner said he hasn't seen an across-the-board pattern.

One Commissioner said he would like some clarification of the plan for the Grand Junction facility, specifically the CAH designation proposal versus use of local hospitals.

Another Commissioner said a key factor in the CAH designation seems to be the level of interest locally. His observation is that the change in attitude from VISN-level to facility-level is very different from one place to another. Another Commissioner agreed, saying that some places are trying to do a good job while others are not.

Proximity and Campus Realignment

The “campus realignment” recommendations are new, having been added after reviewing the results of the proximity initiatives. The category includes two areas – realignment of *services* and realignment of *campuses* – aimed at improving cost effectiveness and quality. The two categories are defined as follows:

- *Proximity* involves tertiary and acute care hospitals within defined mileage criteria.
- *Campus realignment* involves Division II hospitals, which are divisions of another VA Medical Center located on a separate campus.

The purpose of this CARES category is to identify opportunities to consolidate and realign infrastructure arising from the close geographic proximity of other VHA facilities with similar missions. In all, 23 Planning Initiatives were identified during the process. The Draft National Plan focuses on recommendations that would (1) offer cost-effective highly specialized services, and (2) optimize the use of scarce medical specialties.

The criterion for selection as an initiative for *acute care* hospitals was that the facility had to be within 60 miles of another facility. These facilities offer primary care, general internal medicine and limited diagnostic tests and surgeries. They refer complicated patients to tertiary centers for further evaluation and treatment (serving as the “sending area”). For *tertiary centers* the criterion was that the facility had to be within 120 miles of another facility. Tertiary centers offer a full range of diagnostic and specialty treatments, have medical school affiliations and conduct basic research. They serve as regional referral centers (they are the “receiving area”). VISNs generally support one or two tertiary centers.

With regard to the new *campus realignment* concept, VA recognized that Division II hospitals, especially those without acute care beds, had not fully explored the use of space and consolidation of services. Division II hospitals have the following characteristics:

- A separate campus.
- Often providing only outpatient care and non-acute beds (long-term, psychiatric and domiciliary care, for example).
- Integrated with a larger parent facility.
- Attached to the parent facility by common management.

In reviewing market plan submissions for CARES, team analyses resulted in identifying 26 Division II facilities for possible inclusion in the Draft National Plan. The Plan indicates more comprehensive evaluations will be done before implementation.

The criteria used in reviewing facilities for possible inclusion in the realignment initiative were:

- Whether the proposal could be implemented in the next five years.
- Whether the workload could be absorbed at other VA facilities.
- Whether the workload could be contracted in the community.
- The capital investment requirements and savings.
- The potential uses of the campus or excess space.
- Savings of recurring dollars that would be available for reprogramming.
- Whether FTEs could be absorbed in an eight-hour operation or at another site.

The *proximity/realignment* recommendations included in the Draft National Plan fall into five categories:

1. Close VA Services and Enhance Use of the Campus for Veterans. Facilities in this category are: Canandaigua, Pittsburgh-Highland Drive, Lexington-Leestown, Cleveland-Brecksville, Gulfport, Marlin, Waco and Livermore.
2. Convert to Outpatient Services (Eight Hours A Day Operation). Facilities in this group include: Bedford, Montrose, Kerrville, White City, Walla Walla and Knoxville. Kerrville would be converted to a Critical Access Hospital until acute services can be transferred; nursing home and outpatient services would be maintained.
3. No Change. Facilities in this category are: Lyons, St. Albans, Philadelphia-Wilmington, Perry Point (on a realigned campus footprint), Bay Pines-Tampa, and Hot Springs (which would be converted to a CAH).
4. Maintain Facilities And Consolidate Services. This group includes: Brooklyn-Bronx-Manhattan-East Orange, Baltimore-Washington, Nashville-Murfreesboro, Cincinnati-Dayton, Ann Arbor-Detroit, Leavenworth-Topeka, Greater Los-Angeles-Long Beach, Roxbury-Bedford-Brockton-Providence, and Palo Alto-San Francisco.
5. Requires Further Study. The Plan also identifies the following alternatives as requiring further study:
 - *New York-Manhattan.* Feasibility of consolidating inpatient care at Brooklyn, maintaining significant outpatient primary and specialty care at the current site or elsewhere in Manhattan.
 - *Lexington-Louisville.* Study facility during the next cycle.
 - *Augusta Uptown.* Feasibility of realigning the campus footprint and consolidating selected services at Uptown Division or contracting in the community.
 - *Montgomery.* Outpatient-only facility.

- *Lake City*. Transferring inpatient surgery to Gainesville and re-evaluate inpatient medicine when Gainesville expands its inpatient capacity.
- *Big Spring*. Closing surgery and contracting for care in communities nearest the patients. Also study possibility of no longer providing services through other Critical Access Hospital.
- *Vancouver*. Enhance use lease of campus by contracting for nursing home care and relocating outpatient services.
- *Jamaica Plains*. Feasibility of redesigning campus to consolidate services in fewer buildings (for operational savings and to maximize enhanced use lease potential).

During the summer, Commissioners made site visits to eighteen different locations that would be affected by the proximity/realignment recommendations. Information obtained included the fact that leaders in VISNs are actively promoting some Division II campus realignment plans, but that it is not clear that the approaches are consistent. Over the past few years some Division II hospitals have already been consolidating administrative and acute care services at their parent facility. Further, some Division II campuses present the best opportunities for enhanced use leasing.

Q&A/Discussion

Regarding the time frame for the campus realignment recommendations, the Plan did not include specifics, and recommendations are sometimes linked to changes recommended at another facility. Also there are no specific time frames included in the recommendations for further study. One Commissioner said that the Manhattan study is already underway and he expects it to be a traumatic experience. In that case, travel times will be a critical factor. Another Commissioner said noted hearing “Do not close Manhattan” from all sources. A third Commissioner agreed that there will be transportation difficulties in this region and that closing Manhattan might not be the most cost-effective move. That is the reason why the Manhattan closure was moved to the “study” category.

One Commissioner said Directors he had talked with stressed that future changes are dependent on the success of enhanced use leases. He heard talk about golf courses, oil wells and similar things. Another Commissioner said the idea requires further thought. The agency needs to decide whether it is in the health care delivery business or the golf course business.

One Commissioner suggested the Commission should consider recommending establishment of a separate category of money to maintain historic facilities. He doesn’t believe the Directors should be forced to find creative ways to pay for keeping up such properties.

The review of the list of the proximity recommendations for tertiary care facilities indicated that not much was proposed for closure. One Commissioner observed that there seem to be no real plans for consolidation at the Dayton facility. Anything under consideration seems to be pretty far away, time-wise. Another Commissioner said plans are underway to move staff from Martinsburg to Baltimore-Washington. Another agreed, noting that Martinsburg has a good list of services to be consolidated.

It also was noted that the recommendations had not looked across VISN lines very much.

A Commissioner said he is concerned about what message VA might be sending in regard to facilities to be consolidated over a longer period of time. He noted that there will be patients at these facilities for some time to come.

A Commissioner reported that Buffalo has combined and realigned with complete interface with the users and the community and that the facility provides a good example of the importance of leadership.

Another Commissioner discussed the Livermore facility, saying the plan sent forward is not the plan that was adopted. In that case, new CBOCs would have to be created to accommodate the workload volume. These new CBOCs may not be included on the priority list. Another Commissioner added that the stakeholders at Livermore thought it would be converted to an eight-hour operation, not be closed. He said both veterans and employees are upset and concerned about the recommendations. He said the people who work there are committed and dedicated. They had a hard time understanding the process and don't grasp the reasons for downsizing. They want to know what the VA will do for the people who work at Livermore and how the process will work. They are concerned about the short-term impact. The first Commissioner added that the physician who built up the clinic at Livermore is very concerned, and said it is apparent that VA defines "quality" differently in different places.

The Lake City, Florida recommendation was also discussed. Commissioners who visited there noted that the stakeholders mounted active protests and were well-organized. One Commissioner said the leadership there is supportive of 24-7 operations. He said once more CBOCs open in the area they might identify even more needs for important services. Another noted Lake City is in a rapidly growing area and said the proposed changes to be studied may not make sense in view of what's happening to the population. A third Commissioner noted Gainesville is already experiencing stressed capacity. He said that Gainesville will need to be expanded before any services can be moved from Lake City.

One Commissioner said there are many proximity issues involved in long-term care. Not including long-term care in the Plan makes the process of considering the recommendations difficult. The proposals in the Draft National Plan will heavily impact long-term care. They will substantially change the mission of the facilities involved. He believes the Commission should work to ensure retention of the mission to provide long-term care and care for the seriously mentally ill. Services must be retained, and he said he doesn't see this happening yet. This is an issue the Commission will have to handle.

Access; Outpatient Capacity; Inpatient Capacity

Access, outpatient capacity and inpatient capacity are three areas that are separate, but linked.

The access standards that were used to develop Planning Initiatives for the Draft National CARES Plan (DNCP) were:

- For *primary care* – 70 percent of enrollees within 30 minutes driving time for urban areas, 30 minutes for rural areas and 60 minutes for highly rural areas, with fewer than 11,000 enrollees outside these guidelines. Twenty-seven Planning Initiatives were based on primary care access standards.

- For *acute hospital care* – 65 percent of enrollees within 60 minutes driving time for urban areas, 90 minutes for rural areas and 120 minutes for highly rural areas, with fewer than 12,000 enrollees outside these guidelines. Twenty-four PIs were based on this standard.
- For *tertiary care* – 65 percent of enrollees within 240 minutes driving time for urban areas, 240 minutes for rural areas and the within the Network for highly rural areas, with fewer than 12,000 enrollees outside these guidelines. Six PIs were based on this standard.

The VISNs included a variety of solutions to the access Planning Initiatives. Those recommended in the Draft National Plan include:

- For *primary care* – Establishing new CBOCs, either VA-staffed or contracted and joint VA-DoD ambulatory care clinics.
- For *acute hospital care* – Renovating existing infrastructure, referring patients to other VA facilities with excess capacity, contract or leasing with non-VA facilities and joint ventures with DoD.
- For *Tertiary care services* – Contracting with community tertiary care facilities or with DoD.

The DNCP made the point that new access points (such as CBOCs) have historically generated new demand. The DNCP also noted that demand could increase the need for acute inpatient services before infrastructure improvements can be made to meet it. Further, the DNCP indicated that the financial requirements associated with new construction or leasing new access sites, as well as the need for new operating funds, would have to compete with funding for delivering health care services to current and projected enrollees.

The Draft National Plan includes:

- Proposals for 161 new CBOCs in markets where there were access gaps (according to the standards described above), and
- Proposals for 101 new CBOCs in markets where there were not access gaps.

The recommendations included in the Plan prioritize these proposals with the goal of achieving a balanced growth of outpatient capacity and improved access while still ensuring the safety and availability of acute inpatient infrastructure.

Of the 262 new CBOCs proposed, the Draft National Plan recommends establishing *48 new CBOCs as the highest priority*. They would be opened in the next 8 to 10 years. These CBOCs meet 3 criteria: a) large future capacity gaps; 2) an access gap and 3) the number of projected enrollees in the market is greater than 7,000 per CBOC. Also included in the high priority group are those linked to proposed realignments. A second priority group would establish new CBOCs in markets that meet the same criteria as the preceding group but where the enrollees are fewer than 7,000 per CBOC in the market. The third priority group includes markets with large demand gaps but where 70 percent or more of the enrollees are within driving time guidelines. As a result of the prioritization process, the Draft National Plan recommends new CBOCs as primary care access sites in seven VISNs (1, 6, 7, 8, 16, 20 and 23) and hospital and tertiary care access in thirteen VISNs (all of the foregoing plus 10, 11, 17, 18, 19 and 21). All access gaps that deal with hospital and tertiary care seem to be included in the Plan.

As a result of the *site visits*, the Commission learned that many markets are planning to open new CBOCs. Some are planning new CBOCs even though they do not have access gaps. The site visits revealed that stakeholders want more CBOCs and want CBOCs that are now closed to new patients to have increased capacity. A number of CBOCs are closed to new enrollment and patients travel to parent facilities for care

The site visits also pointed out that some markets are including specialty care and mental health care in their CBOCs while others are not – some plans include opening new space in hospitals for specialty care. It appears that some markets that are planning to contract for hospitalization as a means of improving access would contract only for emergency hospitalization and would transport patients to VA tertiary facilities once they are stable. Additionally, some facilities reported that when contracting out, VA receives good prices for the first contract but prices increase significantly for later contracts. This practice may make the cost of contracting prohibitive in some cases.

The site visit findings also seem to indicate that the travel time standards used for CARES may not be reasonable. In highly urban areas, for example, it may appear that the standard is met but actual travel times can be significantly longer than the 30-minute standard for primary care and the 60-minute standard for hospital care. Similarly, in rural and highly rural areas, the community standard is often more than the 30-minute and 60-minute standards established by VA. VISN leadership in rural networks do not believe the standard is practical or that it can be met given the sparse populations of some areas. It was noted that in rural areas, many veterans still travel 150-200 miles one-way for primary care.

Q&A/Discussion

A Commissioner asked whether wait times are included among the factors used in developing the access standard. Only *driving times* are used in determining whether there is an access gap; however, wait times are a part of the problem and they may increase in the future as workload goes up. Another Commissioner expressed the view that VA needs to provide *primary* care as rapidly as possible; patients can access specialty care from there. It was noted that most VA facilities are already operating at capacity. A Commissioner said his understanding is that the demand for beds has been declining. The Chairman said he was told that staffing is a bigger limitation than beds – space is often available but staff is in short supply. It was noted that the demand for new beds is peaking now.

A Commissioner asked how many of the recommended new CBOCs would be staffed by VA staff and how many would be contract operated. The Plan does not specify that, but currently 75 percent of CBOCs are operated by VA staff and 25 percent are contract operated.

One Commissioner noted that some of the highest priority new CBOCs would not be opening until 2010; he said this doesn't seem sensible.

Another Commissioner said he would like to develop a list of questions for VHA and asked if the release of the Draft National Plan had changed the relationship between the Commission and VHA people and whether the “firewall” is still in place. Mr. Larson replied that the firewall is still in place, but encouraged Commissioners to provide him with any questions they would like to have answered by VHA.

One Commissioner expressed the view that the Secretary will need some kind of scorecard that shows the savings and results realized from CARES. He said he hasn't seen anything like that yet. He said he had also heard that contract prices sometimes go up substantially after patients establish relationships with private doctors. He asked whether there was any data about how much of this goes on throughout the system. No such data was available.

Enhancing outpatient care was the next topic. A shift to outpatient care has occurred in VA over the past few years. Between fiscal year 1996 and fiscal year 2002, there was a 53 percent decrease in VA's average daily census and a 54 percent increase in outpatient visits. During that same period, the total number of veterans treated increased by 1.5 million.

The *criteria* for CARES planning initiatives in the three categories of care were as follows:

- *Primary care* – A 25 percent change from 2001 and 26,000 clinic stops. Fifty-three PIs were developed in this category.
- *Specialty care* – Also a 25 percent change in workload from 2001 and 30,000 clinic stops. Seventy-one PIs were included in this category.
- *Mental health* – Also a 25 percent change in workload from 2001 and 16,000 clinic stops. Nineteen mental health PIs were developed.

The CARES model projects increases in overall outpatient clinic stops through FY 2009, then shows a gradual decline through 2022 to approach baseline figures. Within that, the model shows overall growth in specialty outpatient stops and a decline in mental health stops (a figure which is being reviewed).

The *workload solutions* recommended for *outpatient categories* in the Draft National Plan cover a range of alternatives:

- For *primary care* – an additional 20, 640, 184 clinic stops are projected through 2012, and 17, 395, 123 through 2022.
 - Contracts would be used to cover 2,959,588 of the additional stops through 2012 (14.3 percent of the total increase) and 2,175, 508 of the stops through 2022 (12.5 percent of the total).
 - Joint ventures would cover 44,450 additional stops (.2 percent of the increase) through 2012 and 41,450 more stops through 2022 (.2 percent of the total).
 - In-sharing would cover 88,860 additional stops through 2012 (.4 percent of the increase) and 88,860 of the stops through 2022 (.5 percent of the total).
 - In-house expansion would be used to cover 17,547, 286 additional stops (85.1 percent of the increase) through 2012 and 15,089, 305 additional stops through 2022 (86.8 [percent of the total).
- For *specialty care* – an additional 22, 241, 113 clinic stops are projected through 2012 and 19,794, 754 more through 2022.
 - Contracts would be used to cover an additional 3,835, 207 stops through 2012 (17.2 percent of the increase) and 3,056,393 through 2022 (15.4 percent of the total increase).
 - Joint ventures would be used to cover 203,608 additional stops through 2012 (.9 percent of the increase) and 200,950 through 2022 (1.0 percent of the increase).
 - In-sharing would cover 66,518 additional stops through 2012 (.3 percent of the increase) and 66,518 more through 2022 (also .3 percent of the total increase).

- Selling would be used cover 640 more stops in each of 2012 and 2022 (not a significant percentage).
- In-house expansion would be used to cover the additional 18,135,140 clinic stops projected for 2012 (81.6 percent of the total increase) and 16,470,253 more stops through 2022 (83.3 percent of the increase).
- For *mental health* – an additional 10,089, 026 clinic stops are projected through 2012 and 9,318,832 through 2022.
 - Contracts would be used to cover 1,214,262 of the new stops through 2012 (12.0 percent of the total) and 957,536 of the increase through 2022 (10.3 percent of the total increase).
 - Joint ventures would cover the additional 22,200 stops projected for 2012 (.2 percent of the total) and 24,200 of the additional stops projected form 2022 (.3 percent of the total).
 - In-sharing would be used for the 442 new stops projected through both 2012 and 2022 (not a significant percentage).
 - Selling would cover the 530 additional stops projected for both 2012 and 2022 (also not a significant percentage).
 - In-house expansion would be used to cover the bulk of the additional stops -- 8,851,592 projected for 2012 (87.8 percent of the total) and 8,336,124 through 2022 (89.4 percent of the increase).

A key question is how well prepared the VISNs are to implement these solutions.

The alternatives being recommended for managing *outpatient space* in the various health care service categories are:

- For *primary care*, the need for an additional 10, 127,601 square feet of space would be met by using existing non-renovated space (48.1 percent), renovating existing space (9.7 percent), converting vacant space (3.6 percent), new construction (10.5 percent), donated space (.6 percent), leasing (27.1 percent) and enhanced use (.4 percent).
- For *specialty care*, an additional 20,122,112 square feet of space would be obtained by using existing non-renovated space (42.7 percent), renovating existing space (6.5 percent), converting vacant space (6.6 percent), new construction (23.7 percent), donated space (.6 percent), leasing (18.7 percent) and enhanced use (1.2 percent).
- For *mental health care*, the need for an additional 5,740,489 square feet of space would be met by using existing non-renovated space (56.8 percent), renovating existing space (9.4 percent), converting vacant space (5.0 percent), new construction (11.5 percent), donated space (.3 percent), and leasing (17.0 percent).

The Draft National Plan focuses on improving existing outpatient delivery sites as part of an overall strategy of maintaining VHA’s current infrastructure. Existing VHA sites and capital requirements are included in the Plan with priority designations; new outpatient access sites have been grouped into three priority levels.

Information developed during the Commission’s *site visits* suggests several findings. One is that outpatient mental health was not handled consistently among the VISNs. Another is that large numbers of facilities are already operating at capacity for outpatient care, meaning there isn’t significant room for growth. A large portion of specialty outpatient care is delivered at hospitals. The Commissioners also learned that inpatient facilities cannot easily be converted or retrofitted

for efficient use as outpatient facilities. As in other areas, field units have concerns regarding in-house versus contract care for veterans.

Q&A/Discussion

A Commissioner stated he is troubled by the disparity regarding the use of contractors. He said he sees this disparity even *within* VISNs.

Several Commissioners discussed the matter of facility operating hours. During the site visits, some Commissioners were told about the advantages of having only 8:00AM until 4:30 PM operating hours with facilities handling only emergencies at other times. People at the facilities told the Commissioners they believe patients prefer these hours. Several Commissioners questioned this conclusion, suggesting that evening and weekend hours might be popular with patients.

The Draft National Plan’s *inpatient demand* recommendations have been developed in a changing environment for inpatient workload at VHA. Some important environmental changes include:

- A 63 percent decline in acute operating beds between 1995 and 2002 (from 52,000 beds to 19,000 beds).
- A shift to primary care, including home care, case management, telemedicine and patient education.
- Technology enhancements, such as imaging and better pharmaceutical interventions.

A Commissioner commented that the change in funding also had a big impact on the environment for inpatient care.

The criteria used to select Planning Initiatives in this area were: a projected increase or decrease of 25 percent *and* a projected increase or decrease of 20 beds. The criteria applied to acute medicine, surgery and psychiatry bed sections. A total of 60 Planning Initiatives were identified using these criteria, broken out as follows:

<u>CARES Category</u>	<u># PIs With Increasing Demand</u>	<u># PIs With Decreasing Demand</u>
<i>Medicine</i>	23	11
<i>Surgery</i>	3	5
<i>Psychiatry</i>	11	7
Total	37	23

The psychiatry PIs are still under review and recommendations will be developed for next year.

Inpatient *workload trends* show that the overall demand for inpatient beds peaks in 2004 and declines in the out years. Within this overall trend, the figures show that medicine bed demand remains high throughout the planning period, peaking in FY 2008. Others peak earlier -- surgery bed demand peaks in FY 2007 and psychiatry bed demand peaks as early as FY 2004.

The Draft National CARES Plan includes solutions for all identified needs, regardless of whether a PI was identified. The proposals included in the plan, for which no priorities have been specified, emphasize the condition of the facilities, i.e., the need to upgrade or modernize

existing space because of its condition. The gaps considered more significant are those that meet the workload criteria for *both* 2012 and 2022.

Q&A/Discussion

A Commission discussion of all three areas followed.

One Commissioner said if he had to do the process all over again, he would try to figure out what the problem is they are trying to solve. It isn't clear whether the problem is access, cost, quality or something else. He said it seems the CARES process simply works issues without defining the problem.

He said when the Commissioners made site visits, they didn't get a sense that people in the field knew what problem they were trying to solve and how the initiatives would achieve the solution. Most were not sure what they would get as a result of addressing the PIs. He said there was simply no focus on what the problem is.

Another Commissioner agreed, saying it gets back to the need for a "scorecard." There also needs to be a time frame and priorities.

In discussing the treatment of proposed CBOCs, the following statement from the Draft National CARES Plan was read:

"The Draft National CARES Plan attempts to balance meeting national access guidelines with ensuring the current and future viability of its acute care infrastructure. Because of this, while new access points in this VISN are included in the National Plan, they are not in the high implementation priority category at this time." (Appendix A; page 1).

One Commissioner observed that CARES had imposed the additional criterion of "only heavily populated areas where there are 7,000 enrollees." He views this as being a questionable decision – one that will upset veterans in rural areas because it seems clear that preference is being given to veterans in metropolitan areas.

Another Commissioner pointed out that all CBOCs are not the same. Some do not provide specialty care, for example. On a national basis, a Commissioner said headquarters told the VISNs to use the process, and they did. But they should have told them what the problem was and asked them how they would solve it. The Commissioner suggested that *leadership* and *training* should be used – give people the problem and ask them to solve it.

With regard to the various aspect of the access problem: (1) the time to get to a facility, and (2) the time it takes to be seen, a Commissioner noted that if a veteran needs care, he will find a way to get to the facility. For him, the critical aspect is the wait time to get into the system. Another Commissioner said he saw one case where the wait time for access to a primary care facility was 48 hours, but said there is no consistency. A third Commissioner said his experience had been that the wait times are reasonable once a veteran gets into the system, but you don't know how long it might take to do that.

It was noted that the time required to get an appointment, in most cases, is now under 30 days and the waiting times at the facility are usually 20 minutes or less; so the "wait list" is being driven down, albeit slowly. The two problems are limited capacity and a bulging wait list.

A Commissioner commented that it seems like VA can offer primary care but not specialty care. It seems that the program won't be able to get specialty care to the rural CBOCs.

Another Commissioner said he feels no obligation to defend what's in the Plan. That job is up to senior VA officials in the area.

As to relying on either DoD or community providers, one Commissioner said DoD and VA record systems are incompatible, but he believes VA can rely on DoD. He said at one facility he visited, VA provides care to DoD patients within 30 days – which is the DoD standard – but not to VA patients. Another Commissioner said there have also been instances where plans already underway have been disrupted by changes in command at the facility. Some action should be taken to ensure continuity.

Special Disability Programs and Extended Care Initiatives

The *special disability* programs includes: *spinal cord injury and disorders, blind rehabilitation, mental health, homelessness and traumatic brain injury*. Of these, only spinal cord injury/disorder and the blind rehabilitation program are included in CARES. These programs have Congressionally-mandated bed levels.

The CARES goal in these areas was to project the needs of the population served by VA's special disability programs. The problem is these programs are so unique that no comparable data were available elsewhere for use in the CARES model. For *mental health* and *traumatic brain injury*, no alternative methodology was developed. For *blind rehabilitation* and *spinal cord injury/disorders* acceptable alternative methods of data analysis and forecasting were developed and these programs were included in CARES.

For *spinal cord injury and disorders*, VA is using a “hub-and-spoke” concept to deliver care, with SCI Centers serving as hubs and non-Center facilities serving as spokes. SCI projections show an increase in the number of users, leading to the inclusion of recommendations for new and expanded beds in the Draft National Plan. The recommendations are:

- For *acute and sustaining SCI beds* – 30 new beds at Syracuse or Albany, a 20-bed expansion at Augusta, 25-34 new beds at North Little Rock (CAVHS), 30 new beds at Denver and 20 new beds at Minneapolis followed by 40 additional new beds.
- For *Long-term care SCI/D* – 30 new long-term care beds at Tampa, 20 long-term care beds at Memphis (accompanied by a decrease in acute beds from 70 to 60), 20 long-term care beds Cleveland and a conversion of 30 acute beds to long-term care beds at Long Beach.
- *Other SCI/D initiatives* -- Consolidate all SCI beds in VISN 3 at the Bronx facility, keep open the SCI outpatient clinic at Hudson Valley/East Orange until the VISN 4 issue is resolved and begin planning for a new SCI outpatient clinic in Philadelphia.

For *blind rehabilitation*, the Draft National Plan recommends establishing two new Blind Rehabilitation Centers and emphasizing outpatient rehabilitation services for the continuum of care for visually-impaired veterans. Specific recommendations are:

- Establish a new Blind Rehabilitation Center at Biloxi with 36 beds.
- Establish a new Blind Rehabilitation Center at Long Beach with 24 beds.
- Address the projected need for 15 additional Blind Rehab beds in VISN 8.
- Review the need for a 15-bed Blind Rehab Center in VISN 10 due to workload transfers.

With regard to *traumatic brain injury (TBI)*, VHA currently has four Centers: Richmond, Tampa, Palo Alto and Minneapolis. These Centers provide leadership for the additional 19 VAMC and three military hospitals that provide care through the TBI network.

Q&A/Discussion

A Commissioner observed that aging patients not only increase the amount of long-term care needed by those patients, it also increases the need to provide care for their spouses. He also observed that advances have been made in SCI care in recent years and this has changed the need for bed hospitalization. Another Commissioner noted, however, that the average age of SCI veterans is 50.4 years and SCI beds at VA facilities have been at or over capacity for the past two years.

The VA now has 974 acute and sustaining beds in their system and the Plan would add more than 195 new beds. There are about 1,200 long-term care beds in the system and that the figure would increase to 1,500 by 2012. A Commissioner asked to have a spreadsheet prepared showing “authorized,” “operating,” and “ADC” beds by facility.

One Commissioner asked about the data showing growth in the need for new SCI beds peaking in 2022, noting that this is inconsistent with other areas. Another Commissioner asked which facilities have adequate beds. He then asked specifically about Tampa and whether the plan was to add new beds or convert existing beds to SCI care. He also asked whether North Little Rock was slated for acute care or long-term beds.

With regard to the blind rehabilitation recommendations, a Commissioner recalls statements made to the Commission earlier about the huge backlog and long wait times for blind rehab services. She asked about who would be defending the recommendations at the hearings. Another Commissioner asked that the staff develop information on the current Blind Rehab Centers and the numbers associated with each. He also noted VA is sometimes forced to make trade-offs. It often doesn't have space where the veterans are but does have space in other areas where it wouldn't make any sense to put a Blind Rehab Center. He said the wait times are so long it is ridiculous -- several years in some cases. When that happens patients just go away instead of wait. He said there is an average wait list of 2,500 people.

The Commission was next briefed on the *mental health, domiciliary and homelessness* aspects of the Draft National Plan. The Plan does not address *mental health* and *long-term care*.

Regarding *mental health*, consultations with the Mental Health Strategic Health Group and the Seriously Mentally Ill Committee led VHA to conclude that: (1) the mental health projections need further study, (2) the projection methodology needs further review, (3) utilization rates need to be focused on program mission and content, and (4) the alternative projection methodology should be linked to the VetPop database.

Until the drivers affecting the CARES projections for psychiatry and related programs can be studied and understood, the programs were held constant. Outpatient mental health services, for example, were held constant where *decreases* in workload were projected, as were all non-benchmarked residential rehabilitation programs. *Increases* in workload were accommodated in the CARES program and are to be managed by various appropriate actions, including in-house expansion, incorporating mental health services into existing and expanded CBOCs, new construction, renovation and reconfiguration of existing space, telemedicine and contract services and/or leasing space. The Plan also includes integrating outpatient mental health at all sites and, in one Network (VISN5), joint ventures with DoD.

Q&A/Discussion

A Commissioner asked whether the planned expansions in this area include extended hours. VHA looked at that but concluded that it isn't practical because patients don't like to come out after hours or on Saturdays. The Commissioner noted that in the private sector the demand for weekend and evening services is growing. Another Commissioner agreed, saying his experience is that many private services are open at night and on weekends. To him it seems an excellent way to expand the use of capital assets.

In the area of *extended care*, veterans needs in this area have been met in traditional settings by the VA, including VA nursing homes, contract community nursing home care and state veterans homes. VA's objective for long-term care is treatment in the least restrictive setting. Veterans must meet the eligibility requirements set forth in the Millennium Health Care and Benefit Act for Veterans.

As with mental health, the VA extended care forecasting model was inadequate for use during the CARES process and is being revised. It is expected that improvements will be made in time for the next strategic planning cycle. Specifically, changes are needed to remove the bias toward using nursing home care over non-institutional alternatives (such as assisted living). In the meantime, no CARES Planning Initiatives were developed based on projected workload gaps. However, the VISNs did submit capital investment proposals to address space conditions. In all, proposals were received from nine VISNs for nursing home care investments: St. Albans and Hudson Valley (VISN 3), Perry Point (VISN 5), Beckley (VISN 6), Cleveland-Wade Park (VISN 10), Denver (VISN 19), American Lake and Walla Walla (VISN 20), Menlo Park (VISN 21), Las Vegas and West Los Angeles (VISN 22) and Des Moines (VISN23).

Pending the outcome of the revised projection model, long-term care workload increases in other areas will be managed through a combination of actions, including:

- Using enhanced use leasing to establish assisted living facilities.
- Enhancing assisted living facilities for veterans' spouses.
- Making capital investments in new and renovated space to remedy deficiencies.
- Assisting homeless women veterans with dependent children through collaborative arrangements.
- Leasing building to community agencies to provide domiciliary-like space.
- Establishing new domiciliary presences.

VHA will include specific proposals for long-term care improvements in the 2004 VA strategic plan.

One Commissioner said the Commission would need to look critically at the projections behind some of the proposals included in the Draft National Plan, citing American Lake and Walla Walla as examples. Another Commissioner added that the Commission should also look at the private sector presence, which he characterized as “significant” in some areas. A third Commissioner observed that “domiciliaries” are not programs. They are facilities where programs take place.

Infrastructure

The Draft National CARES Plan’s objective regarding its *infrastructure* recommendations was to enhance current infrastructure so that VA health care services could be delivered in a modern, functional health care environment. The CARES approach was to evaluate all areas and develop the most efficient “footprint” for health care delivery. Overall, the Plan provides for a 42 percent reduction in vacant and underutilized space (from 8.6 million square feet in 2001 to 4.9 million square feet in 2002) with savings of over \$45 million a year.

The process assessed all critical components, including physical plant and vacant space, to assess the condition of the space and establish a database. Space was scored on a scale of “1” (low) to “5” (high). Any space receiving a score of less than “3” was identified for renovations to bring it up to a score of “5.”

Seismic strengthening improvements were given priority because of their safety implications. There are 63 sites on the priority list for seismic strengthening improvements totaling \$440,652,872. It was noted that apart from seismic strengthening projects, the Draft National Plan provided only minimal cost data.

In considering infrastructure alternatives the Plan gives a lot of attention to the potential of *enhanced use leases*. Enhanced use leasing is attractive because it addresses workload gaps and presents revenue-generating opportunities. The Draft National Plan includes 18 enhanced use lease initiatives. An additional 52 enhanced use lease opportunities were identified, but haven’t yet been fully developed by the Networks. From the site visits, it appears that there is a lot of frustration about the enhanced use lease process because of how much time it takes. Many years would be required before any income could be realized from land divestiture.

The CARES process also reviewed all *vacant space* and considered possible dispositions, including conversion, leasing and demolition.

In addition to safety and functionality issues, parking availability emerged as a priority consideration, both in terms of access and in terms of employee needs.

The Draft National Plan addresses potential collaborations and opportunities for joint space arrangements with other agencies, including the Veterans Benefits Administration, the National Cemetery Administration and the Department of Defense.

While the Draft National Plan speaks to the process used to assess facility infrastructure and determine the amount of space needed to deliver health care at the service levels projected, it is largely silent about specific proposals.

During the site visits, Commissioners were told about the need for seismic reinforcement projects in selected areas. They also were provided first-hand information about the frustrations with the time required for enhanced use leases. Some proposals take so long that community entities lose interest in the proposals and discontinue the effort.

O&A/Discussion

A Commissioner observed that VHA needs to address GAO's concerns about spending \$1 million a day for facilities that aren't being used. It won't be sufficient to just state that the GAO estimate is bogus.

Another Commissioner noted that seismic improvement projects are focused on the West Coast. He also said these projects were already in the pipeline but were frozen pending completion of CARES.

With regard to vacant space, one Commissioner said it has been experience that nobody ever wants to get rid of anything. This can be a real problem.

Several Commissioners discussed their observations about enhanced use leasing. One said the site visits seemed to indicate that VA may have the wrong people in enhanced use lease jobs. This might be part of the problem that the VISN are having. She said there are problems with state laws that make enhanced use leasing difficult. Another said the lease process is so cumbersome and involved that people take other actions or just walk away from projects. As an example, a project was cited in which Congress became so disenchanted with the enhanced use lease process that it simply appropriated the money to build a new regional office and a potential new community hospital on VA land. A third stated that the problem is internal to VA.

A Commissioner asked whether the staff had a bottom-line figure for new construction. He noted that the Plan estimated a total of \$4.6 billion over 20 years and said this amount sound low to him.

Relationships

The final broad category of recommendations addressed in the Draft National Plan is relationships. The category includes relationships and potential joint ventures or collaborations with:

- Medical school affiliations
- Research.
- Unions and employees
- The U.S. Department of Defense.
- Other major components of the U.S. Department of Veterans Affairs – the Veterans Benefits Administration and the National Cemetery Administration.
- State veteran homes.

With regard to *medical school affiliations*, VA is the world's largest single provider of training for health professionals -- 130 VA facilities have affiliations with 107 medical schools, trained 76,000 students in 2002 and support 8,800 physician resident positions. Without these affiliations, VA would have difficulty delivering high quality patient care.

Consolidations have produced mixed results from the viewpoint of medical school affiliations. The Draft National Plan expresses a preference for maintaining facility-based academic affiliate programs but recognizes that shared leadership of academic programs is difficult in practice and that supervision of residents with dual affiliation is an ongoing challenge.

Fifteen affiliations would be affected by the actions proposed in the Draft National Plan. The degree of consolidation varies from place to place and is not always significant. The affected facilities are:

- Brooklyn/Bronx
- Brooklyn/East Orange
- Manhattan/East Orange
- Manhattan/Bronx
- Manhattan/Brooklyn
- Bronx/East Orange
- Baltimore/Washington
- Nashville/Murfreesboro
- Ann Arbor/Detroit
- Cincinnati/Dayton
- San Francisco/Palo Alto
- Greater LA/Long Beach
- Leavenworth/Topeka
- Pittsburgh-Highland Drive
- Gulfport/Biloxi

Concerns raised during site visits and discussions with stakeholders included:

- VA plans to contract for care.
- The adjacency of support services.
- Parking.

Research in the Draft National Plan is treated as a non-clinical service that does not generate workload directly. However, the market plans submitted by the VISNs identify 20 new research initiatives having an associated cost of approximately \$469 million.

With regard to *employee and union relationships*, the Plan includes statements on union involvement, and not much more. A Memorandum of Understanding was developed between VA and the American Federation of Government Employees (AFGE) to establish local union representation on all CARES planning committees. VISN market plans were submitted to the union's Partnership Council.

As stated in the site visit reports, Commissioners learned that employees are concerned about (1) the potential loss of jobs that would result from contracting out care, consolidations and mission changes, (2) the quality of contracted care, (3) the loss of clinical professional positions, and (4) career transition planning.

Concerning **VA/DoD sharing**, there is a tremendous potential for savings through sharing medical services among federal medical providers and there are numerous collaborative opportunities available to DoD and VA. The Draft National Plan identifies 74 Planning Initiatives in Appendix I aimed at improved facilities and services sharing with DoD in five different priority categories:

- High Priority—acute demand, substantial mutual advantage, DoD construction proposed and high visibility.
- Near Term – High potential, contemplation of facilities, discussion in current fiscal year.
- Future – Potential, but no compelling reason for immediate planning – to be considered after 2005 BRAC.

- Good Ideas – Little or no impact on capital investment programs, not in purview of the CARES process.
- Local Development – Potential advantage not readily apparent.

During the site visits, several concerns about VA/DoD sharing were raised with the Commission. One was the limited access to military bases. Another was that sharing is difficult during times of military deployment. A third was that credentialing is difficult. The final concern was that current reimbursement methodologies are not flexible.

Another aspect of VA/DoD relationships concerns the VA role as the primary backup for the DoD in wartime. As part of the CARES process, VISNs were required to discuss the impact of their PI solutions on this “fourth mission” of VA. The market plan solutions in the Draft National Plan did not propose significant downsizing of acute beds in any facility designated to play a receiving center role. Further, none of the small facilities scheduled to eliminate beds as part of the Draft National Plan is designated as a receiving center. Additionally, closures proposed due to proximity criteria will not have an effect on receiving in those markets. A potential problem was noted in Las Vegas, where a new Air Force squadron might impact the VA presence.

Concerning *relationships with the Veterans Benefits Administration (VBA) and the National Cemetery Administration (NCA)*, a goal of the CARES process was to consider strategies that integrate health care demand planning with efficiencies in rent and property management through collaboration with these other major VA components. As a result, the Plan recommends:

- Six VBA collocations by FY 2010 (Newington, CT; Columbia, SC; Albuquerque, NM; Los Angeles, CA; Reno, NV and Minneapolis, MN).
- Eleven additional collocations by 2016 and one more collocation by FY 2022.
- Seven high-priority collocations with NCA (VA Hudson Valley HCA and Montrose; Salem; Sabana Naval Facility at San Juan; Chillicothe; Leavenworth and St. Louis; Walla Walla; and West LA).

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Insufficient acreage and the unsuitability of VA Medical Center sites presented challenges to collocations with NCA.

The Draft National Plan did not address VHA relationships with *state veterans homes*. However, several of the Commission’s site visits involved significant discussions of state homes. These were VISN 9 (Kentucky), VISN 19 (Colorado-Rifle), VISN 20 (Washington and Oregon), VISN 23 (Iowa-Knoxville) and VISN 23 (South Dakota-Hot Springs).

Q&A/Discussion

One Commissioner said he had understood the CARES plan was supposed to minimize the impact on career employees. The Plan includes that statement and notes that “town hall” meetings about CARES were held with employees. The Commissioner followed up by saying that concerns were raised during the site visits.

A Commissioner commented he had learned they are trying to save Ft. Buchanan in San Juan by offering it to the VA as a hospital site. Another Commissioner observed that some of the

collaboration opportunities he had heard about were not much more than just an idea at this point. Many of them have not been developed. One Commissioner said the military seems more eager for collaboration than the VA, leading another to suggest that the two secretaries need to get together to “make it happen.”

Commenting on the state veteran homes, one Commissioner said California has three new homes on the drawing boards and their preference is to build new facilities rather than collaborate with VA.

Concerning the medical affiliates, one Commissioner said they are on board with the proposed changes in New York. A second said he had only seen medical affiliates once during his site visits. A third Commissioner suggested this lack of testimony might mean things are going pretty well; it does not mean the affiliates are not interested. The second Commissioner said veterans know the difference between teaching hospitals and other facilities and will travel to places where there are medical affiliates.

Commenting generally, a Commissioner said the Draft National Plan does not come together in the way one would expect of such a plan. It lacks things like “critical success factors” and other elements expected in a strategic plan. Further, it does not appear that there is a “national plan for a system of care” that addresses all of the various parts, such as the relative roles of CBOCs. She asked what the CARES staff is doing while the Commission is in the field and what kind of coordination should be occurring.

The Executive Director responded by saying he meets weekly with the CARES staff. They will be doing cost analysis during the time the Commission is having hearings and reviewing possible changes to the CARES model. He suggested the Commission report might want to emphasize the need for continuing coordination.

On another matter, Mr. Larson said he is projecting that the Commission might be ready to present its recommendations to the Secretary by December 18. He said there would be additional discussion about the matter later.

Thursday, August 7, 2003

Chairman Alvarez called the session to order and introduced Dr. Robert Roswell, Under Secretary for Health.

**Presentation By
Dr. Robert Roswell
Under Secretary for Health
U.S. Department of Veterans Affairs
Draft National CARES Plan**

Dr. Roswell began his presentation on the Draft National Plan by explaining handouts presented to the Commission and reviewing the CARES process leading up to the current Plan. He said the first handout provided a set of definitions, most of which should be familiar to the Commission. The one new item on this list is Critical Access Hospital (CAH). He said CAH is a new concept in the context of VA health care. The essential characteristics are that the hospital is remote with no other inpatient facility nearby. The facility would have no ICU or

surgical services. It would be primarily a take-in point for other facilities or for relatively minor illnesses.

Dr. Roswell continued his presentation on his Plan and how it was implemented in the VISNs with the following:

[Click here for Dr. Roswell's Power Point Presentation.](#)

Q&A/Discussion

The Chairman thanked Dr. Roswell for his presentation and opened the floor to questions from the Commission.

Regarding the proposed move in VISN 3 of the psychiatry and domiciliary services from Montrose, a Commissioner said he thought the policy was not to reduce the number of these kinds of beds. Dr. Roswell replied that the VISN has been told to maintain the number of beds. Another Commissioner observed that the Plan calls for a significant reduction in the number of beds in some cases, such as Des Moines and Waco. He said there will need to be oversight to make sure patients aren't lost. He said patients with psychiatric needs are the ones most likely to fall through the cracks. He is concerned that the changes will need to be done well.

Dr. Roswell said there is still a lot of work to be done and they will have to look carefully at the details. He also said CARES didn't try to close psychiatric care at long-term facilities. The recommendations are driven by cost considerations. Acute service facilities (including associated services such as laboratories) are expensive to build and to maintain. The obvious answer was to consolidate those services in tertiary care facilities. Long-term and psychiatric care needs are still under review and will be handled later. He said he understands the concern and agrees with it.

One Commissioner asked whether the Paralyzed Veterans of America had taken a position on the potential transfer of SCI care in this VISN. Dr. Roswell said he has not spoken with PVA about the proposal.

With regard to the *critical access hospital (CAH)* designation, one Commissioner asked how VA tested the marketplace to come up with critical access hospital designations. Dr. Roswell replied that they hadn't tested the market in all cases, certainly not as well as they would have liked. Dr. Chang added that CARES was more concerned about quality. Another Commissioner said asked what criteria were used in selecting small facilities for the CAH designation. Dr. Chang said the Draft National Plan lists some of the criteria in Chapter 8 and Appendix F. Dr. Roswell acknowledged that there are community hospitals available in some areas where the Plan proposes to designate a facility as a CAH. However, the VA facility would provide an entry point into the system in those areas.

Another Commissioner said the Commission was told that there would be criteria. Dr. Roswell said he doesn't think the criteria are rigid. They will cover what the facility will do *after* its designation as a CAH. The criteria for designating facilities as critical access hospitals are still open. Asked whether VA would be using Medicare criteria, Dr. Chang replied they would be using some Medicare criteria but that VA can have its own criteria and they will be flexible.

Dr. Roswell stated the critical point is not providing ICU care. He said what the VISNs were supposed to address were “capacity” and “access” issues. When all of those gaps were addressed, no needs for new hospitals were identified except those proposed (Orlando, Denver and Las Vegas).

A Commissioner commented that the “CAH” designation seems to be mainly avoiding the pain of closure. Dr. Roswell said CARES tried to look at the clinical need for the hospitals along with all available options, such as contracting with community facilities.

Another Commissioner expressed the view that facilities so designated shouldn’t be continued beyond a reasonable economic lifetime, which could be very short in some cases.

Dr. Roswell said the discussion was getting into fundamental policy issues. As an example, he cited the South New Jersey area, where there is a maximum need for 20-22 beds. VA wouldn’t build a facility for that level of demand, but the Congressman does not want veterans going out of state to Delaware for service. In that case, the only option available is non-VA providers. The problem is VA wants to maintain tertiary care services and privatization might mean the loss of a critical mass for specialty care.

A Commissioner observed that CBOCs are well accepted at the local level. There is a preference for getting care locally.

Dr. Roswell said VA does not want veterans to lose their identity. It is important for VA to maintain the range of services and specialties needed to provide unique services such as spinal cord injury care. Dr. Roswell said he would also like to have legislation that would allow private insurance and Medicare to pay for contracted services for veterans. He noted that the “Tricare for Life” program allows Tricare to be a Medigap payer.

A Commissioner questioned the validity of the apparent VA assumption that local resources are either not available or are not adequate in many areas. He suggested that VHA staff should be careful about the reasons they give to justify a facility’s designation as a CAH.

Noting CARES’ extensive plans for *contracting* with private sector providers, one Commissioner asked how VHA planned to avoid problems with contractors. Dr. Roswell replied VHA would have to work with the contractors or get new ones.

As an example, another Commissioner observed that the Plan for VISN 8 called for contracting a very large number of beds. Dr. Roswell replied that the advantage of using contracts is that you only pay for what you use. When VHA builds a facility, it has to pay for everything all the time. In answer to another question about contracting -- for nursing home care -- Dr. Roswell replied that the advantage in this case is being able to locate people close to home.

Speaking to the Butler, Pennsylvania, proposal, a Commissioner suggested VHA might consider changing a one-division hospital to a two-division hospital in that case.

Another Commissioner asked about the criteria for seismic strengthening projects. Dr. Roswell said he would provide a detailed answer, but that they have to do with what would happen if the facility were to collapse.

One Commissioner said he does not believe VA has the capability to conduct a functional *enhanced use lease program* now. The process takes too long and proposals go away. He believes the staff capability to run the program just isn't there. He also said where to draw the line in terms of uses is an issue.

Dr. Roswell agreed that the enhanced use leasing program is broken at the current time. He believes it is a Congressional issue. The process must be streamlined or it will not work.

He reiterated his preference for establishing assisted living facilities using enhanced use lease authority. He said there is a self-imposed moratorium on assisted living facilities in VA right now and ALF pilot in Portland. He emphasized that assisted living facilities are considered to be "housing" not "medical care." VA would like private providers to develop ALF facilities on VA property.

Dr. Roswell noted that just walking away from a property would generate savings. If VA sells the property, the money goes into the Treasury general fund. But enhanced use leasing generates *revenue* for up to 75 years. VA can also ask the private sector to pre-pay the lease. He said some VA properties could be very valuable. If VA can find private people who are willing to pre-pay the lease, it can use the money to fund new construction. It could be a significant source of funds. Further, any funds realized would be retained locally and there is a requirement that enhanced use lease funds must be used to benefit veterans.

A Commissioner asked if there are any limits or boundaries as to what uses VA can consider. He cited golf courses as an example.

Dr. Roswell said that decision is a policy decision and not one for him to make. He did say that if VA were walking away from a campus he wouldn't care how the property is going to be used as long as it generates revenue. However, if VA is going to maintain a presence on the site it must be far more careful about how the property gets used. For example, if private providers are going to build an assisted living facility on a property, VA would like to provide medical services to go with it.

On another subject, a Commissioner asked why VA is proposing to close facilities before it finishes looking at the needs for long-term care. Dr. Roswell said the cost of renovating marginal 50-year old buildings is high. You would not get a good nursing home out of such a renovation. It is both cheaper and better to build a new nursing home than to try to convert older facilities.

The Commissioner said experience has shown that when a facility is converted from a patient care services (PCS) facility to a nursing home, the PCS culture continues to prevail. Dr. Roswell agreed and said that isn't appropriate. VA needs to be in the business of providing residential long-term care.

Asked about the possibility of using mobile clinics, Dr. Roswell said VHA is considering some of these, particularly for homeless outreach. They would make extensive use of electronics in providing care.

One Commissioner express concern that proposed CBOCs in rural areas might fall off the table as a result of the CARES prioritization process. He fears veterans in these areas will feel like they have been betrayed – that they participated and lost. He asked Dr. Roswell to explain the rationale for taking the small CBOCs out of the plan.

Dr. Roswell said he believes the small number of CBOCs is justified. CARES asked for the recommendations. He only prioritized them based on the 7,000-patient criterion. Dr. Roswell said he would like the Commission to look at areas where there are access issues but lack a critical mass of enrollees.

Another Commissioner asked the source for the 7,000 figure. The response was that it was a natural “break point.” Asked whether new CBOCs beyond the high priority 48 would be opened by 2010, Dr. Roswell said probably not. A Commissioner asked how VISNs would explain this to their stakeholders. He said explaining the decision to those who will be disenfranchised is not the Commission’s job; it is a VA leadership job. Dr. Roswell agreed. He also said the situation looks inequitable in the National Plan, but that was the way VHA loaded the playing field. It was a trade-off with other services. The implementation process will be complex.

A Commissioner asked about the VA process for reducing the *waiting list* backlog and how active it is. Dr. Roswell replied that each VISN has a coordinator who is looking at options. He added that the preference for extended hours versus 8-to5 operations is variable among veterans.

Another Commissioner asked how VHA would be doing *performance evaluation* – how progress and results will be evaluated for such factors as wait times and service improvement and whether a scorecard would be established for each facility. Dr. Roswell said he needs to do that. VHA has a comprehensive performance evaluation system in place. It measures wait time and patient satisfaction and includes over 200 measures. He said the entire CARES system is based on measurement. Quality, access, timeliness and satisfaction were all measured. He added that the measures do not yet include “cost” but they need to. Financial measures will be developed.

Asked about trends in VA *tertiary care*, Dr. Roswell said he is distressed about what has happened over the last few years. He noted there is a much greater demand for services than was anticipated when VA opened its CBOCs. Now VHA does not have sufficient resources to provide enough staffing and equipment to meet the needs. He observed that the average lifetime of a cardiac cath lab is only eight years. He agreed that VA has ignored tertiary care requirements in order to expand primary care and said it cannot continue to do that.

Another Commissioner, acknowledging that patients seem well satisfied with the care they are getting, asked how VHA gets rid of marginal employees. Dr. Roswell said a far greater problem for him is figuring out how to replace the large numbers of people who will be leaving the system in the next five years. Because of that situation, the Draft National Plan increases the clerical workforce.

With regard to *stakeholder reactions*, Dr. Roswell said it was not used to develop the Draft National Plan. Stakeholder input was used to develop the VISN plans. His office put together the *national* plan based only on VISN input. He acknowledged that there often was not time to get stakeholder input on changes to VISN plans. He said the Commission would get stakeholder input on the National Plan.

Following up, a Commissioner asked what communications have been held with VISN directors about what was done with their plans and whether communications will occur before the Commission goes out for hearings. Ms. Miller said VHA has begun the communications process and there will be continuing discussions.

The Commissioner asked Dr. Roswell to explain the interface between the VISN plans and the Draft National Plan – whether the National Plan supersedes the VISN plans and whether the VISN plans are still viable. He said the National Plan does supersede the VISN plans. He is responsible for what was done with the VISN plans. The VISN plans are now archival. They show what the stakeholders provided. Dr. Roswell said the Commission’s prerogatives include re-visiting VISN plans, but he wants the Commission to vet the *National Plan*.

Asked how he would prioritize specific projects for funding, Dr. Roswell said the strategy is to get a large block of money that will be available for capital requirements without being tied to specific projects. The Secretary will choose which projects go to the top of the list.

A Commissioner raised the need to develop some kind of scorecard for the proposed changes that shows improvements, savings and other factors. He said he hopes somebody is working on it. Dr. Roswell agreed with the need for such a scorecard, although he said it will be hard to get answers in some cases. He also said there are some areas where VHA can’t get people to provide the services needed even if resources are available.

Another Commissioner asked if the Blind Rehab service waiting list of 2500 people is an example of that type of situation. Dr. Roswell said waiting lists are not necessarily undesirable. In the case of blind rehab, he said there is ample time. The caseload in that area is predictable. VHA needs to tailor how care is provided. It needs to be more selective, not “one size fits all.”

Chairman Alvarez said the Commission is aware that work is being done on the Milliman model and that it had asked for sensitivity analysis to be performed as part of that work. He asked whether the Commission would have access to the new model results and whether new data would be available on August 15 as planned. Dr. Roswell said the Commission would certainly have access to any new information resulting from model improvements. He noted that forecasting is a continuous process, so he is not sure about the August 15 date. He also said that the sensitivity analysis would be done, but he is not sure when.

A Commissioner observed that the last-minute closures and consolidations seem not to have been as well thought through as the earlier plans. He asked whether the Commission would have an adequate information base about these recommendations to use for the hearings since the changes are not included in the VISN plans. Dr. Roswell said his office would have people at the hearings. He also said the VISN people may have their own views. Mr. Larson added that he has asked to have staff resources available at the hearings to answer questions from veterans. Dr. Roswell he will have support staff available at the hearings along with copies of the Draft National Plan. He said local VA employees are advocating for positions that are not part of the National Plan.

Another Commissioner asked whether the VISN staff are supposed to support the National Plan, not the VISN plans. Dr. Roswell said the National Plan has politically sensitive recommendations that will make for difficult relations with some stakeholders. The VISNs feel compelled to support their stakeholders and local interests. The Commissioner observed that the

Commission is not necessarily supporting the National Plan. Dr. Roswell said that is correct, but he is asking the Commission for recommendations on the Draft National Plan, not on the VISN plans. However, he acknowledged that the Commission might want to reference the VISN plans when it comes up with recommendations.

One Commissioner asked what assumptions were made about the annual level of capital investment and what incremental gain there would be from going to a higher level. Dr. Roswell said CARES had made no attempt to constrain construction costs. The Commissioner said CARES could have gone for more CBOCs and asked why that didn't happen. Dr. Roswell said the CBOC recommendations were partly constrained by non-financial factors such as other changes planned and alternative approaches to meeting the need. Asked why VHA had constrained the total level to \$4.6 billion, Dr. Roswell said he has to be pragmatic about expectations. Additionally, VHA also needs to get operating money and needs to rebuild its tertiary infrastructure first.

Asked what will happen if VA closes a facility and then can not get an enhanced use lease deal, Dr. Roswell said VA will sell the facility or just turn it over to GSA. Sometimes VA will not have an alternative use for a facility.

The Chairman, in line with his statement after Dr. Burke's presentation on the CARES Model, and the concerns raised by Commissioners, presented the following to the Commission, which agreed to its incorporation into the record:

The Commission agreed that the VHA Health Care Enrollment and Expenditure Model provides a reasonable analytical approach for estimating VA enrollment, utilization and expenditures for the purposes of the CARES process, with the following reservations. Final acceptance of the model would be subject to the outcome of actions now being taken to revise the model. It is expected that the revised model will provide appropriate improvements, which will include a sensitivity analysis and address the planning initiatives/gaps identified for the timeframe beyond 5 years.

**U.S. Department of Veterans Affairs
Capital Asset Realignment for Enhanced Services (CARES) Commission**

August 7, 2003
Crystal City, Virginia

Administrative and Preparatory Session

Chairman Alvarez opened the administrative session, which was closed to the public. He began by informing the Commission that the Secretary's Office has been telling people the Commission would finish by November 30, not December 31. However, he had agreed with the Secretary to submit the Commission's report by the end of the year.

The Chairman said the main purpose of the session is to have a free and open discussion of the Commission's role and to allow individual Commissioners to air their views in preparation for the upcoming hearings. He hopes to achieve a common understanding of what the Commission is supposed to do before going into the hearings. He stressed again that the Commission is an independent body and is not necessarily endorsing the Draft National Plan.

Discussion of the Commission's Role and Information Needs

One Commissioner began the discussion by asking whether there would be room for minority opinions in the report when it is written. Chairman Alvarez said there would be. He would prefer to reach consensus, but there will be room for minority opinions after the process is completed.

Another Commissioner said he is looking for objective information that can be used to determine return on investment. He wants to know what is expected to result from the proposals included in the Plan. He said the parameters for justification are very wide. The Chairman agreed, saying what the Commission has now is just a list. A third Commissioner added that there is also no timetable, which adds to the marginality of the Plan's value. The Chairman said the implications are that the recommendations will have to have a lot of caveats.

Another Commissioner said he would like VHA to give the Commission a complete list of the recommendations it wants the Commission to pass on to assist the Commission's interpretation of the Plan. He also would like to have a 4-5 page executive summary of what the Plan is trying to accomplish. He believes this should come from VHA. This document will make the Commission's job more achievable. Without it, he isn't sure how to evaluate the proposals included in the Plan. He said VHA should also tell the Commission where to find data to support the proposals. He observed that the Commission has three possible decisions it can make: concur, disagree or agree there is not enough information. He suggested a memo be sent from the Chairman to Dr. Roswell asking for what the Commission needs. This statement received support from other Commissioners.

Another Commissioner said the list of recommendations should include an amplification of what VHA is proposing and what the justification for it is. He said he is disappointed in the Executive Summary included in the Draft National Plan. Yet another Commissioner needed guidance as to what to do with the information he gets from the hearings.

Another indicated confusion about what VHA is proposing in regard to long-term care facilities and CBOCs.

A Commissioner suggested that if the Plan is for real there ought to be timelines.

When a Commissioner asked to see the April 15 Plan that was rejected and to have a list of the things the VISNs proposed that did not get accepted, Mr. Larson said the kinds of information the Commission is asking for was in many of the market plans that were submitted. The rationale for the Draft National Plan is coming from Dr. Roswell; up until April 15, the Plan was data-driven.

A Commissioner said he believes Dr. Roswell thought the original Plan was not courageous enough so he sent the VISNs back to the drawing board and that the only thing the Commission can deal with is the current Plan. Another Commissioner said the expectation is that the Commission will look at the VISN market plans *and* the Draft National Plan before it makes recommendations.

As an example of what he is looking for, a Commissioner said the Commission might want to recommend that some of the CBOCs proposed by the VISNs be added to the priority list of forty-eight. He is asking for the detail that would allow the Commission to get at that.

Mr. Larson said the original submissions varied tremendously in their level of detail. A Commissioner asked whether the Commission could get information about what alternatives were considered but rejected, and why.

With regard to the hearings, Chairman Alvarez said the Commission's job is to deal with the Draft National Plan. The Commission won't have to answer VISN questions or deal with VISN concerns about the original proposals. The Commission will question the VISNs, not the other way around. The Commission is not the defender of the Plan. The key question for him is "What is the Commission's task and how does it do it?"

A Commissioner said the Commission *will* hear what the original Plan was when it goes out for hearings. Consequently, he believes the Commission should know what that Plan was. Chairman Alvarez replied that the Commission will have access to that Plan, but that it *must* deal with the National Plan now on the table.

Another Commissioner observed that where the decision is to build a hospital, the question that has to be answered is "Why?" He believes the Commission's job is to say whether or not it is a good idea and whether there are other alternatives. He said he doesn't see how the Commission can make recommendations in a political vacuum.

A Commissioner said some of the recommendations in the plan are circular, such as the New Mexico-San Antonio proposals. There needs to be a definite decision, not something tied to future events that might or might not happen. Chairman Alvarez said the Commission can and should make recommendations about such things, in an objective manner. A Commissioner said he would like to have market plan information in the same format as the National Plan so he can compare the two when he goes into a hearing. Given that the mini-market plans are in the same format as the Draft National Plan, Chairman Alvarez said the staff will get the mini-market plans to the Commissioners in a usable format so that the Commissioners can ask good questions. It is important for the Commissioners to have enough information so they can understand the testimony being presented and develop good questions.

One Commissioner said he would also need information about what criteria VHA used to develop the specific proposals in the National Plan. For example, he would like to know what criteria were used in deciding to build a new facility. Mr. Larson said he is concerned that if he just sends a generic request for information to VHA he won't get any answers until after the hearings are over. He wondered if it might be better to craft questions that are tied to specific proposals. The Commissioner suggested that the need is to do *both*.

Chairman Alvarez said he wants to get information soon to use in forming questions for the hearings. Commissioners should also provide specific questions related to the issues for each hearing.

One Commissioner noted that the Commission could find that it evaluated the data and the proposal is or is not reasonable. It could also say that it did not have enough data to evaluate the proposal and make a recommendation.

Chairman Alvarez said the Commission may have no choice in the matter given the timeframe.

Another Commissioner said she believes the key question is “How will the Plan meet what needs?” The Chairman replied that the Plan provides a basis for dialogue.

Another Commissioner said he has a question about the Orlando proposal, which is “Why there?”

A Commissioner suggested that all of the VISN directors be asked whether they understand why their priorities were or were not reflected in the National Plan. He believes they should be knowledgeable enough to understand what was done and why and why their priorities did not surface if that is the case.

Chairman Alvarez emphasized the issue of the Commission’s independence. . The Chairman said the Commission would need to know a lot – priorities, timeframes, alternatives and other information-- to deal with the issues raised.

In pursuing its mission, one Commissioner stated that there are no questions that the Commission cannot ask– the Commission should be able to ask whatever it wants. The Commissioner said the Commission will need to press stakeholders who want to be at the hearings just to posture on the reasons for their requests. Commissioners should not be afraid to ask the tough questions.

The Chairman said it will be important to stick to the format concerning the time allowed for each witness. Another Commissioner added that it will also be important for individual Commissioners not to express their views publicly at the hearings. Asked how questions from the media are to be handled, the Chairman said that the chair of each hearing or his or her designee would deal with the media.

Chairman Alvarez said the Commission’s credibility depends on conducting a neutral, objective hearing process.

Another Commissioner agreed, saying that the key information needed for each recommendation is what it is and where the rationale for it can be found.

Discussion of Hearing Protocols

Regarding witnesses at the hearings, a Commissioner asked what the plan is for dealing with people who are not on the witness list but who show up to testify anyway. Chairman Alvarez said the hearing chairs will have to explain that the hearings are a formal process and discourage

such witnesses from testifying. However they are welcome to provide statements for the record and one or more Commissioners may want to meet with them on the side.

Decision on Acceptability of the Projection Model

A motion was raised that the Commission decide on the reasonableness of the demand model used in the CARES process.

The Commission agreed that the VHA Health Care Enrollment and Expenditure Model provides a reasonable analytical approach for estimating VA enrollment, utilization and expenditures for the purposes of the CARES process, with the following reservations. Final acceptance of the model would be subject to the outcome of actions now being taken to revise the model. It is expected that the revised model will provide appropriate improvements, which will include a sensitivity analysis and address the planning initiatives/gaps identified for the timeframe beyond 5 years.

Discussion of Logistics

Mr. Larson explained that the travel forms have been revised and simplified. Copies are included in the Commissioners' meeting books along with a narrative explanation of GSA rules. He emphasized that the GSA per diem rates are local and cover meals and incidental expenses. On the first and last day of a trip, the traveler gets only three-quarters of a day. If it is a one-day trip, the traveler gets nothing for less than 12 hours. He said the staff will provide the allowable meals and incidental expenses rate for each city the Commission is going to – they will fill in the form.

On the claim form (travel claim, not honorarium), Commissioners are to fill out the top part plus ground transportation and so forth on the bottom. Other claims go in the middle section. Commissioners should have no lodging expenses – the VISNs are letting contracts with the hotels where the Commissioners will be staying. Commissioners should not pay for their hotel rooms. They will be asked to provide a credit card for personal expenses only, but Commissioners must not let the hotel charge their lodging expenses to the card.

Mr. Larson said receipts are not needed for under \$75.00. He requests that Commissioners submit a separate claim form *for each trip*.

Honorariums will continue to be vouchered on a monthly basis using the same form – no changes have been made to that process.

Ms. Lai emphasized that the M&IE rate will be based on where the Commissioner spends the night.

Regarding airline travel, staff has completed the arrangements for everything except the first week in October and has e-mailed itineraries to the Commissioners. Commissioners will get their e-tickets two weeks before the scheduled travel. He asked Commissioners to minimize personal changes to the reservations because of the time factor involved. He also discussed routing and seating arrangements and how they could be changed. Mr. Larson said once the plane lands, Commissioners will be met and escorted to all locations and return flights.

Discussion of Hearing Logistics

Mr. Larson said there will be three documents at the hearings: a list of the Commissioners and two lists of scheduled panels (one for the public, one for the Commission with additional information).

After each hearing, a post-hearing summary will be prepared using a standard format. Mr. Larson distributed a draft of the suggested format based on a version of what was used for the site visits. The format is intended to summarize (a) the hearings and (b) Commissioners' views.

There will be three staff for each hearing: a subject matter expert, who will be responsible for content and briefings; a scribe, who may also be a backup subject matter expert; and a logistics person. The job of the scribe is to capture the hearings and Commissioner views "on the ground" and report to the Executive Director in 48 hours.

As a result of the earlier discussion concerning information needs, a new section was added to the standard report format for "post hearing questions for VHA (Dr. Roswell)." One Commissioner said the questions should be boiled down to those, which are essential.

Detailed logistical arrangements for both teams are nearly complete.

Mr. Larson next discussed the schedule proposed for the initial hearings and follow-up meetings on August 12 and 13. Hearings will be held in the field on Tuesday – one team in Baltimore and the other in Cleveland. The Commission will meet in the Commission offices on Wednesday for post-hearing caucuses, after which there will be a plenary session to discuss "lessons learned." In the afternoon, the teams will meet to prepare for the rest of the hearings.

For post-hearing coordination, the plan is for Mr. Larson to send the reports to the Chairman and to Commissioners Vogel, Battaglia, Ferguson and Wyrick. Mr. Larson also suggested that a weekly conference call among the five would facilitate cross-communication between the teams. It will also ensure the Chairman is informed on a timely basis about trends and issues.

Mr. Larson said opening statements for the hearings had been prepared in draft form and are included in the notebooks behind Tab 10. There are two versions – one for use when the Chairman is present at the hearing and one for when he is not. When Chairman Alvarez is present, he will open the hearing.

**U.S. Department of Veteran Affairs
Capital Asset Realignment for Enhanced Services (CARES) Commission**

August 13, 2003
Washington, DC
Administrative & Preparatory Session

Commissioners in Attendance:

Everett Alvarez, Jr., Chairman	Layton McCurdy
Charles Battaglia	Richard Pell, Jr.
Joseph E. Binard	Robert A. Ray
Raymond Boland	Sister Patricia Vandenberg
Chad Colley	Raymond John Vogel, Vice Chairman
Vernice Ferguson	Jo Ann Webb
John Kendall	Al Zamberlan
Richard McCormick	

Chairman Alvarez opened the meeting stating that the purpose of this session is to help prepare for the upcoming hearings by reviewing the Commission's first public hearings, held the previous day, on August 12, 2003, in Cleveland and Baltimore. He expected that there would be information that would help staff and commissioners in the conduct of the future hearings.

Invitation Process

The initial discussions were about what procedures to follow with regard to those organizations, which were invited to provide testimony to the Commission, but which did not send a representative or provide written testimony. The discussion was initiated because representatives from affiliated medical schools were missing from the first hearings. It was suggested that contact be made with the AAMC to advise that attendance would be appreciated. Further, the Chairman instructed Commission staff call individuals who have not responded to the invitations. If requested or to encourage attendance, staff could provide approximate times for the expected beginning of the relevant panel. This would limit the amount of time those providing testimony would need to take from their schedules in order to attend and speak.

It was also decided that staff should ask contacts at the VISNs and other local sources to provide names of local veterans' groups and public officials from areas that are significantly impacted by the Draft National CARES plan. Also included in this discussion was the need to hear from local leaders of VSOs, to make sure that these individuals represented the local veteran concerns and not a national VSO party line. The Commission wants to ensure that it hears from local groups, whether their opinions of the plan are in favor or against the plan as it affects their VISNs. Establishing additional panels at some locations will be considered on a hearing-by-hearing basis.

It was noted that it is important to have collaborative partners where the issues exist, and also to ensure that the appropriate person from DoD appear to discuss potential VA / DoD projects. The DoD representative at the Baltimore hearing acknowledged that he did not have the authority to respond to certain Commission questions and is working to arrange for higher-ranking individuals to attend future hearings.

Hearing Management and Logistics

To make better use of time, VISN leadership will be requested to summarize their written statements rather than read them. This will leave more time for Commissioners to ask questions.

By consensus, it was determined that staff should advise elected officials in advance of the fact-finding nature of the hearings. It was decided that the general rule would be to allow only those elected officials who were designated to be on a panel the opportunity to testify. If others, in particular staff to elected officials, appear and request to testify, the individual hearing chair would have the discretion to determine whether to give that opportunity. The rationale is that the Commission is interested in the positions of the officials as representatives of their constituents and staff were not elected to represent the local communities.

It was determined that better guidance needed to be given to VISN staff assigned to assist in collecting comments from the public at the hearings. The VISN staff needs to be advised that the Commission is accepting written comments but will be unable to respond to questions posed in the individual comments. Signage and VISN staff should not encourage the public to submit questions.

Commissioners discussed their roles and mission. It was determined that decisions were not being made at the hearings, but rather that the hearings were being conducted to gather information and to provide an opportunity to the Commission to ask questions on the draft plan and to listen to the issues and concerns raised by local stakeholders.

Additional Requests for Information

It was requested that the VISN 12 Network Director be invited to meet with the Commission to discuss lessons learned from phase 1 of CARES underway in that network.