

**Statement of
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Veterans Health Administration
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Michigan Market

Mr. Chairman and Members of the Committee, thank you for the opportunity to discuss the CARES (Capital Asset Realignment for Enhanced Services) Plan for the Michigan Market in VISN 11, the Veterans in Partnership Network. The CARES process has been an excellent challenge and a historic opportunity to actively and openly participate with our internal/external stakeholders in planning for our future together. As a result of this effort, we believe that the CARES Market Plan for Michigan will be more responsive to the future needs of our veterans in VISN 11. With appropriate funding, we are very motivated to proceed with the implementation phase of these planning initiatives and hopefully these discussions today will assist us in that effort.

In preparing for the CARES process over this past year, VISN 11 established a comprehensive network-wide communication system and identified the network's Executive Leadership Council as the final decision-making body for the Plan. The communication system included the development of an interactive Website, facility level educational sessions, multiple articles for a wide variety of network/facility publications, and the completion of two rounds of market meetings to educate and formulate the planning options. After three active CARES Work Group sessions and Management Assistance Council (MAC) meetings, the Executive Leadership Council approved the option of choice for each planning initiative on March 26, 2003. The VISN 11 CARES Plan is in alignment with the goals and objectives as described in the Phase II National CARES Guide dated June 18, 2002, the Handbook for Market Plan Development dated January 2003, the national signed Memorandum Of Understanding with the AFGF, and subsequent electronic guidance through the National CARES Program Office and the VISN Support Service Center. All of this activity has been jointly accomplished at the network and facility levels since the official CARES Kick Off on June 6, 2002.

Overview – CARES Baseline FY 2001

The mission of VISN 11 is to provide comprehensive high quality health care, train health care professionals and provide support to DoD. To accomplish this mission our healthcare network provides services for veterans and others who primarily reside in a four-state, 173-county catchment area, covering 90,100 square miles. This large and geographically diverse network includes all of Central Illinois, a large portion of the State of Indiana, the lower peninsula of Michigan, and northwest Ohio. Nearly 1.5 million veterans reside within the network service area, representing 6% of this nation's total veteran population. Some 250,000 or 16.8% of the total veterans in the service area are currently enrolled at the eight major care sites in this network. In FY 2001, we served nearly 175,000 unique patients with 85% of those veterans in Priorities 1 through 6. Just over 22,000 of those patients were served on an inpatient – hospital stay basis while the remaining patients were served at the 29 ambulatory care locations across the network. In alignment with VHA's emphasis on ambulatory care and the CARES baseline year, over 2.2 million stops or 1.5 million visits were provided in this network during FY01. In regards to the research and education components of the mission, VISN 11 supports 320 GME positions and over 1,300 training positions for other direct care (nurses, pharmacists, audiologists, technicians, dietitians, dental) and other allied health professionals. Five of the eight major care sites have active VA and non-VA research projects that generated over \$35.2 million in grant funding during FY 2001. DoD support is rather limited in VISN 11 because there are no active duty military bases, forts or stations in the network catchment area. We do have an aggressive TRICARE and FEDS HEAL programs that provides care for the small active duty members/family population, retirees, and reservists.

VISN 11 is a key player in meeting VA goals regarding veteran satisfaction, access, cost effectiveness, expanded primary care service and service integration in an effort to provide a seamless continuum of care. Over the past few years, Congress has increased the VHA medical budget but at the same time, decisions surrounding eligibility reform and redefinition of the VA basic benefits package have introduced the opportunity for large numbers of veterans to enroll and to obtain access to a broad range of services. Budgetary considerations and other performance goals are driving all networks to find ways to provide care more efficiently. Critical network activities in the areas of Quality, Cost, Access and Communication are as follows. (It should be also noted that on May 16, 2003 VISN 11 provided this Commission a summary of the most significant changes in the network during the past five years. This summary has not been duplicated within this testimony but it certainly reflects some of the major milestones that have challenged all our care sites in this network.)

- All network facilities participate in nationally recognized external accreditation processes, including Joint Commission on Accreditation of Healthcare Organizations (JCAHO), selected facilities for the Commission on Accreditation of Rehabilitation Facilities (CARF) and all facilities for the College of American Pathologists (CAP). The most recent JCAHO survey process was conducted in this network in the fall 2000, with hospital accreditation scores ranging from 86 to 93. VISN 11 is preparing for the next cycle of JCAHO examinations this year.

- VHA has also undertaken an aggressive national performance measurement system, including establishing baseline performance and outcome goals in the areas of prevention, clinical guidelines and chronic disease management. VISN 11 on a quarterly basis monitors our achievements and makes adjustments to those programs that are not meeting these important performance measures.
- Numerous activities are underway to improve waiting times in all clinics. Network facilities participated in a collaborative initiative with the Institute for Healthcare Improvement (IHI) to decrease waiting times in clinics and delays for veterans obtaining appointments and have initiated numerous actions to ameliorate these delays in this network. Improvements in waiting times have been achieved but increased demand for service, space limitations, critical staff vacancies and resource constraints continue to present daily challenges. We continue to develop additional solutions to meet the wait time performance standards.
- In 1998, VA launched its National Center for Patient Safety, designed to apply "systems approaches" to patient safety. Since that time some specific actions taken include implementing bar coding for medication administration and computerized order entry. The current objectives of the patient safety program are to identify system problems and solutions, not to assign fault to individuals. VISN 11 has supported extensive staff education and training programs to develop skills in identifying sentinel events and conducting root cause analyses.
- The Network has responded to budgetary challenges by shifting care to less costly settings, developing a continuum of care across facilities to reduce unnecessary duplication, closing unneeded hospital beds, standardizing supplies and pharmaceuticals, and expanding use of blanket purchase agreements. In order to meet the projected health care needs of veterans, VISN leadership continues to address efficiencies such as standardizing volume contract purchases, leveraging resources through partnerships, the expanded use of information and other technologies and developing new enhanced use lease projects to reduce overhead and generate new revenue streams. VISN 11's FY01 budget allocation was \$721 million. Critical network initiatives, e.g., CBOCs, leases, special projects, employee education, fire and safety program and national program support were funded at a level of \$10 million. Prosthetics special purpose funding as distributed from VA Central Office totaled \$26 million in FY01. Facility-specific Research and Education support funding also comes from VA Central Office for those facilities that are actively engaged in these two important programs.
- As addressed earlier, VISN 11 has moved significantly from a healthcare delivery system traditionally rooted in inpatient care to a more outpatient-based system. An integral part of the expansion of outpatient access is the establishment of new Community-Based Outpatient Clinics (CBOCs). VISN 11 has 21 CBOCs currently operational, with 14 additional CBOCs proposed network-wide through the CARES process to address CARES access issues. Twelve of the 21 CBOCs are located in the Michigan Market and they are: Benton Harbor, Flint, Gaylord, Grand Rapids, Jackson, Lansing, Muskegon, Oscoda, Pontiac, Toledo (Ohio), Traverse City, and Yale. The Grand Rapids CBOC is co-located at the Michigan State Veterans Home. While the primary care workload plans for the CBOCs ranged from 500 to 5,000 patients per year, almost all of the CBOCs have met or exceeded their planned capacity. In FY01, the network also budgeted \$1 million

- to expand mental health services to each CBOC with services to be provided, as needed, by psychiatrists, psychologists, social workers and/or advanced practice nurses.
- In response to the requirements of the "Veterans Millennium Health Care and Benefits Act," VISN 11 has established plans to increase the VA nursing home average daily census. Plans include improved staffing levels and reallocation of staff, increased patient referrals to VA nursing home units, and the re-designation of some long-term care unit beds as nursing home beds based on evaluation of current patient needs. The total long-term care needs are addressed across the network through a combination of VA nursing home, contract nursing home, state veterans home, home-based primary care, and community-based services.
 - Investments in information technology will and have already had a positive influence on access, timeliness and quality. VISN 11 telemedicine initiatives include tele-psychiatry, tele-ophthalmology, tele-radiology pilots and tele-home care for the LTC patient.
 - As with the CARES process, communication with our internal/external stakeholder groups is a high priority throughout the network and is an on-going process. With the organizational activation of the networks in 1996, VISN 11 implemented a Management Assistance Council that is comprised of veterans service organization representatives, affiliates, employee unions, volunteers and others that meet quarterly to advise the Network Director on such program matters as service delivery, customer satisfaction, tactical/strategic planning, activation of new programs, marketing, budget implementation, and communication. We also have stakeholders directly participating with our strategic planning committee, service line boards, and other special study groups throughout the year. Additionally, in order to assure these communications across all care sites, the network has designed a Veteran Service Officer (VSO) Forum. The first Forum was held in December 1997 with approximately 75 national, state and county service officers in attendance. The program grew to over 100 attendees at the 2001 Forum. These Forums cover a wide variety of topics important to veteran groups including eligibility, women's health, service line development, program changes and access. VISN 11 staff work closely with our colleagues in the Veteran Benefits Administration regional offices in Detroit and Indianapolis to meet veterans' needs regarding compensation and pension (C&P) examinations. In the network, 99% of C&P exams are found adequate for rating purposes by the regional office rating boards. In a collaborative effort to continuously improve performance, VHA and VBA officials in this network developed joint performance standards to reduce incomplete C&P examination rates and to provide training to VBA rating specialists in the use of electronic medical record information. Our CARES communications with our stakeholders during this past year have been captured in Appendix A.
 - VISN 11 currently has 289 structures located on 637 acres of property within the four-state catchment area. The total amount of square feet in these structures is over 7.5 million. There are 142, or almost one-half of all structures in this network's inventory, that are designated historically significant by the National Historic Registry. This historical registry building count is the highest in the VHA and these structures are located at three facilities: Battle Creek (1920's), Illiana HCS (1890's) and the NIHCS-Marion Division (1890's). All three sites have been aggressively compressing their large campuses' to reduce their overhead costs, submitting plans to historic agencies/societies, and pursuing enhanced use leasing and sharing opportunities.

The Michigan Market & Proposed CARES Actions

This mixed urban/rural market currently serves some 931,457 veterans who primarily reside in Lower Michigan (68 counties) and Northwestern Ohio (10 counties), stretching from the City of Toledo in the south, to the mid/small-sized communities of Traverse City and Mackinaw City to the north. There are major topographic barriers in the area: Lake Michigan to the west, Lake Huron to the north and east, and Lakes St. Clair and Erie to the east and southeast. The Michigan Market is well served by six major interstates and a viable state highway system. One major metropolitan airport and ten mid-sized airports also provide the area with an adequate passenger/mail air system. As a result of the new veteran/enrollee population estimates released in January 2003, there are currently 131,810 (14.2% Market Share) VHA enrollees in the area, and that number is expected to progressively increase to 153,600 (21.5% Market Share) by the year 2012 and then decline to 140,600 (24.6% Market Share) by the year 2022. VA's Michigan market share is the smallest in the country because of the preponderant large/medium sized automobile and manufacturing industries located in this market (quality health benefits available). Today, the Michigan Market is comprised of the Ann Arbor Health Care System, the Battle Creek, Detroit and Saginaw VA Medical Centers, and the twelve CBOCs located in Benton Harbor, Flint, Gaylord, Grand Rapids, Jackson, Lansing, Muskegon, Oscoda, Pontiac, Traverse City, and Yale; and the large CBOC located at Toledo, Ohio. Because of the Great Lakes surrounding three sides of the Market, these facilities almost exclusively serves the entire Michigan Market. In 2001, over 11,191 enrollees (unique individuals) were served on an inpatient basis while the ambulatory care program provided care to over 98,900 enrollees. During this same time, there were 524 Hospital and 320 Nursing Home staffed-operating beds all located at the four major care sites. On the outpatient side of the clinical inventory, the VA facilities and CBOCs provided 796,069 visits or 1,165,027 stops during FY 01. Patients requiring tertiary care are transferred to either the Ann Arbor HCS or the Detroit VA Medical Center for that sophisticated level of care.

In February 2003, the National CARES Program Office identified six significant Planning Initiatives (PIs) for the Michigan Market and they are:

- A. *The projected outpatient primary care workload is expected to increase significantly for the period FY2001 and FY2022 (282,610 stops in FY 01, to 496,435 stops in FY 12, and to 428,722 stops in FY 22).*
- B. *The projected outpatient specialty care workload is expected to increase significantly for the period FY2001 and FY2022 (219,133 stops in FY 01, to 556,162 stops in FY 12, and to 504,497 stops in FY 22).*
- C. *The projected beds for the Saginaw VA Medical Center are well below the 40-bed threshold and as a result, a Small Facility PI was generated for this facility (21 beds projected in FY 12 and 17 beds in FY 22).*
- D. *The AAHCS and the Detroit VAMC are located within 60 miles of one another and as a result, created a Proximity PI for these two tertiary facilities.*
- E. *There is a significant increase in the Medicine beds projected at the AAHCS and the Detroit VAMC (AAHCS 37, to 74, to 58 beds; Detroit 42, to 68, to 52 beds).*

F. There is significant Vacant/Underutilized Space at the AAHCS site (55,976 gsf), Battle Creek site (108,086 gsf), Detroit site (71,727 gsf) and Saginaw site (18,350 gsf).

VISN 11 and the Michigan Management/Stakeholder team identified strategies, options and an option of choice for each of these six PIs and the Mental Health initiative at their two market meetings in December and March. In some cases, the team developed up to four viable options for a given PI. The VISN 11 CARES Coordinator, Assistant CARES Coordinator, CARES Facility Liaison, and VSSC staff assisted this market with the associated current and projected workload and the refinement of options surrounding each PI. It should be noted that the CARES process was placed on hold from mid-January through mid-February to re-run the veteran population and associated workload. Nevertheless, each market developed an option of choice that was ultimately reviewed/approved by the CARES Work Group, MAC and the ELC. VISN 11 proposed solutions are as follows:

- A. To address the significant workload gap for outpatient primary care, VISN 11 plans to increase the outpatient primary care workload from the FY 01 base of 282,610 stops to 496,435 stops in FY 12, and to 428,722 stops in FY 22. We plan to enlarge the program by converting, renovating, and/or leasing additional space primarily at the six (includes the Grand Rapids & Toledo CBOCs) major care sites. We plan to expand the current over crowded Grand Rapids CBOC through a new EU Lease arrangement with a local community healthcare provider/hospital in the immediate area. In addition, four additional CBOCs are planned in Clare, Mason, Monroe and Washtenaw Counties, in the State of Michigan. By adding these four new clinics, the Michigan Market will decrease the number of stops at the parent hospital by some 14,500 primary care stops and improve the access to care for the Michigan veteran. As a result of these actions, the access standard for outpatient primary care in this market will improve from 70% in FY 2001, to 75% by the year 2012, and remain at 75% by the year 2022.
- B. To address the workload gap for outpatient specialty care, VISN 11 plans to increase the outpatient specialty care workload from the FY 01 base of 219,133 stops in FY 01, to 556,162 stops in FY 12, and to 504,497 stops in FY 22. Within the scope of the specialty workload we intend to augment our Blind Rehabilitation Outpatient Services (BROS) Program at all six major care sites. As with the primary care program, we will enlarge the program by converting, renovating, and/or leasing additional space primarily at the six major sites. Some specialty programs may also be added at selected CBOCs and because of the significant importance and increase in the workload projected for this program area, a network implementation group has already been formed to address the projected demand.
- C. To address the Small Facility PI at the Saginaw VAMC, VISN 11 plans to close the acute care beds at this facility. The projected number of beds/ADC for this facility in FY 2012 is 21 beds/18 ADC and in FY 2022 17 beds/14 ADC. These projections are significantly below the 40-bed threshold, and we believe we can improve the quality of care in the Saginaw area by proposing the following by the year 2012: (1.) Maintain 6-8 Intermediate Beds in the existing NHCU for observation and transition – pre/post hospitalization to another community provider or the AAHCS or the Detroit VAMC; (2.) Increase the contract hospitalization program in both the Saginaw area by 2 ADC and by 4 ADC for the veteran in the northern parts of Lower Michigan i.e., Traverse City,

- Charlevoix, Cheboygan, Presque Island communities and (3.) transfer 3.5 ADC to both the AAHCS and the Detroit VAMCs. Winters in the upper half of Lower Michigan can be very difficult, and we believe these actions will improve both the access to care and the quality of care.
- D. To address the Proximity PI, VISN 11 conducted an extensive analysis of the existing and projected workload for both of these tertiary facilities that are located some 46 miles apart from one another. The complete Proximity study is available at the VSSC CARES Website, VISN 11 Documents Section. The analysis depicts two very busy tertiary facilities that will continue to expand their inpatient and outpatient programs through the year 2022. The Michigan Market is large, diverse and generating enough workload to justify their continued existence despite their proximity. From a cost utilization standpoint, the study further evaluates the high cost/high technology services e.g., open heart surgery, neurosurgery, as recommended in the CARES Handbook. VISN 11 and the two facilities evaluated that potential and found that the two are already sharing the following high cost/tech/support services: Open Heart Surgery, Interventional Cardiology, Neurosurgery, Cochlear Implantation, Nuclear Medicine Network, Sleep Lab, Gynecology Cytopathology, GRECC, HSR&D, Contract Administration, Prosthetic Management, Chaplain, Facility Management, Security and MCCF. Discussions with both facilities depict that the two are planning to share other programs in the future: Home Oxygen Program Management, and Radiology Interpretation Services. The projected workload through the year 2022 and the continued sharing of services approach is consistent with the CARES guidance and supports the continued existence of these two large tertiary facilities.
- E. As addressed above, the two tertiary centers for the Michigan Market need to increase their Medicine Beds to meet the projected workload gaps. The Ann Arbor HCS beds are projected to increase from 37 in FY 01, to 74 in FY 12, to 58 in FY22 while the beds at the Detroit VAMC will change from 42, to 68, to 52 respectively. At Ann Arbor, we are planning to convert vacated space through a remodeling (minor construction project) to accommodate these beds. At the Detroit VAMC we are planning to activate an existing nursing unit to meet these projections. Additional staffing to activate these units at both sites will be a challenge as there has been realignment of staff to address the significant increases in the ambulatory care workload over the last several years.
- F. All four facilities in the Michigan Market have vacant/underutilized space. Of the available 2.612 million square feet in the Market just over 254,100 or (9.7%) is vacant. The distribution by care site is as follows: AAHCS site (55,976 gsf), Battle Creek site (108,086 gsf), Detroit site (71,727 gsf) and Saginaw site (18,350 gsf). Forty-two per cent of the vacated space is located at the Battle Creek VAMC. As addressed earlier, this site is compressing its campus to reduce its overhead costs, and planning enhanced-use lease agreements for the use of the vacant buildings/property for the mental health and veteran continuum of care projects. Additionally, all four facilities will convert vacated space to address either the increase of inpatient beds (AAHCS and Detroit) or convert the vacated spaces to address the expanding ambulatory care programs (primary/specialty outpatient care).

Closing Comments

VISN 11 continues to face a myriad of challenges including managing within appropriated funding; exercising stewardship of all resources; continuously improving quality and veteran satisfaction with that care; fully integrating administrative and clinical programs and processes; investing in capital improvements and information technology; increasing market share; and effectively communicating with veteran groups, labor partners, educational affiliates and other VHA community stakeholders. The new CARES process has allowed this network to look progressively towards the future and work with our VHA community to develop viable strategies to meet those health care needs. This historic effort is significant and with dedicated and new resources we are looking very forward to the implementation phase of this process. I am confident that the leadership/staff in the Michigan Market are equal to those challenges and we appreciate the Commission's role in positioning VISN 11 for the future.

Appendix A

VISN 11 CARES Stakeholder Involvement

VISN 11 has attempted to listen and discuss the health care options with our internal/ external stakeholders throughout the CARES process. The VIP Network has compiled the following communication history of those stakeholder events:

- A. All major stakeholders received a letter from the Network Director explaining the CARES process and soliciting their active participation, June 2002.
- B. In June/July 2002 - the CARES Coordinator conducted a site visit to all facilities in VISN 11 to explain the CARES process. A letter and phone call was made to all local major stakeholder offices inviting them to this CARES educational program.
- C. On December 17, 2002 – The CARES Coordinator conducted the first market meeting in the Michigan Market; Network Director letters of invitation and follow-up phone calls were sent to all major stakeholders. This session provided stakeholders with information about the CARES process, requirements, market definition, projection model results for population/ workload, and discussion about various options to address the service gaps.
- D. On March 14, 2003 – The CARES Coordinator conducted the second market meeting in the Michigan Market; Network Director letters of invitation and follow-up phone calls were sent to all major stakeholders. This session provided updated information about the CARES process, new requirements & model results, disclosed all the preliminary options to address the service gaps, and asked for feedback for improvement to those options.

Letters of invitation for the first information session and the two series of market meetings were sent to a variety of stakeholders including: all major VSOs, unions, affiliates (3), state officials including state home directors & other major community contributors to the VHA mission. The CARES Coordinator also met quarterly with the multi-disciplinary Management Assistance Council. A briefing with this group was conducted on April 9, 2002 to discuss all the CARES options developed. We have sent flyers, facility & network newsletters that have contained numerous articles on the CARES process/products. VISN 11 also developed an interactive website that informed all stakeholders of the progress of CARES.

At the facility level, town hall meetings were conducted with employees, volunteers, VSOs, affiliates, unions and other interested parties. Monthly meetings with VSOs were conducted and the care sites provided employees and patients with flyers, handouts, and articles from local papers. Each facility CARES Liaisons and Public Affairs Officers orchestrated all facility events, publicity, and products.

The VIP Network also established an advisory committee to the Executive Leadership Council. The VISN 11 CARES Work Group met on three different occasions to discuss the process, planning initiatives developed by the NCPO, and the options developed to address the approved Planning Initiatives. The CARES Work Group is comprised of senior VISN staff and three AFGE Presidents. This Group developed the final options for ELC review, consideration and final approval.