

**Statement of
VA Sierra Pacific Health Care Network
Department of Veterans Affairs
before the
CARES Commission
on the
VA Sierra Pacific Health Care Network
Market Plan
Including
North Coast Market Plan
South Coast Market Plan
Pacific Islands Market Plan**

**October 1, 2003
Livermore, California**

Mr. Chairman, and members of the Commission, I am pleased to be here today to share with you the VA Sierra Pacific Network (Network) CARES Market Plan. In addition to the Network level Market Plan, today's Hearing will focus on three of our six CARES Markets: the North Coast Market, South Coast Market and the Pacific Islands Market. As you are aware, the CARES process is a data driven process that allows the CARES Markets to align programs and space to meet future demand based on projected enrollment and utilization. The CARES IBM Model requires each Veterans Integrated Service Network (VISN) to address how they will allocate and manage workload and space through FY 2022. The Network and CARES Markets developed planning solutions to resolve identified Planning Initiatives. It is my belief that although the CARES II process is not a panacea for improving all aspects of how we deliver health care, it does provide a focused road map of how we can improve access, provide quality health care in a safe environment, provide the right health care at the right place in a cost effective manner and reduce underutilized and unneeded space.

Our formal testimony will provide a comprehensive understanding of the VA Sierra Pacific Network and Network Market Plan. We will:

- Identify our Network CARES priorities
- Outline the Network's area of geographic responsibility
- Discuss three of our six markets that will be covered in today's Testimony
- Provide a brief summary of CARES Projections at the Network level, and
- Then take a closer look at the North Coast, South Coast, and Pacific Islands Markets by:
 - Discussing the CARES Market Projections and Planning Initiatives, and
 - Identifying the Planning Initiative Solutions that have been developed to resolve workload and space gaps.

Network CARES Priorities:

VA Sierra Pacific Network (VISN 21) has identified critical CARES priorities in three domains:

- Safety
 - Funding of critical seismic construction projects
- Access
 - Approval of new Community Based Outpatient Clinics (CBOCs) to improve access, and to support campus realignment
- Efficiency
 - Approval and funding of Livermore Campus Realignment Initiatives
 - Approval of Enhanced Use initiatives

Network Geographic Area of Responsibility:

The VA Sierra Pacific Network (Network) has a service area that spans over 472,000 square miles. This service area includes central and northern California from Tulare in the south to the Oregon border in the north. The Network also includes northern Nevada, Hawaii, the Philippines and several Pacific Islands including Guam and American Samoa. For CARES purposes, the Network is divided into six Markets, which for the most part are the same geographic areas as the current major Primary Service Areas (PSAs) established for the six Network health care systems. These six health care systems manage a total of 36 sites of care in 71 counties. The market descriptions included below will provide detail for those markets where the CARES market boundary differs from the health care system PSA.

CARES Markets	Health Care Systems	VAMC Location
South Coast	VA Palo Alto Health Care System	Palo Alto, California
North Coast	VA Medical Center, San Francisco	San Francisco, California
Pacific Islands*	VA Pacific Islands Health Care System	Honolulu, Hawaii (Tripler Army Medical Center)
North Valley	VA Northern California Health Care System	Sacramento, California
South Valley	VA Central California Health Care System	Fresno, California
Sierra Nevada	VA Sierra Nevada Health Care System	Reno, Nevada

** For the purposes of CARES, the Philippines, Guam and American Samoa workload data are not included in this phase. As such, the Pacific Islands CARES Market includes only Hawaiian Islands workload data.*

Network Level CARES Projections

▪ **Demographics and Workload**

Although the Network’s veteran population is projected to decline by 41% from FY 2001 to FY 2022, the enrollees are expected to decline by only 15%. During the same time period, the market share is expected to steadily increase from 21% in FY 2001 to 30% in FY 2022.

Network Demographic & Workload Data

VISN 21	FY 2001	FY 2012	FY 2022
Est. Vet. Pop.	1,234,254	936,134	716,508
Enrollees	253,799	257,471	216,224
Market Share	20.6%	27.5%	30.2%
Inpatient BDOC*	182,816	178,370	135,067
Outpatient Stops	2,332,741	3,200,992	2,724,521

**Inpatient Bed Days of Care includes: Acute Medicine, Surgery, and Psychiatry Beds only.*

As noted in the chart above, inpatient care as measured by Bed Days of Care, decline by 26% from FY 2001 to FY 2022. At the same time outpatient workload, as measured by stops, is expected to increase by 17% from FY 2001 to FY 2022.

For the Acute Inpatient Bed Categories, where workload changes are projected for CARES (Medicine, Surgery and Psychiatry), the total number of acute beds required in the Network are projected to remain constant through FY 2012 with changes only occurring within Bed Sections. However, by FY 2022 the total acute beds are projected to decline by 125, or 24%. These changes are summarized in the following table:

**Projected Network Acute Bed Demand
(Treating Facility Based)**

CARES Category	FY 01 Operating Beds	Change in Beds FY 01- 12	Total Beds FY 2012	Change in Beds FY 01- 22	Total Beds FY FY2022
Medicine*	217	+26	243	-30	187
Surgery**	120	-32	88	-49	71
Psychiatry	178	+6	184	-46	132
Total	515	0	515	-125	390

**Includes acute Neurology and Rehab Medicine Beds*

*** Does not include surgical bed reductions for North Coast Market, San Francisco VAMC (-19 beds in FY 2012 and -28 beds in FY 2022. Pls removed by National CARES Project Office due to data validity questions.*

Network Stakeholder Involvement

The Network involved stakeholders through its six Market’s feedback forums, which is provided in more detail in the Market Testimony sections. The Network provided briefings to members of the Management Assistance Council throughout each phase of CARES. Articles were published in the Network’s quarterly newsletter, *Veterans Health Matters*, and distributed to more than 78,000 patients within the Markets. An additional 15,000 issues were distributed to each health care system for placement in high traffic areas. A web site was established to disseminate information and acquire comments from stakeholders. The Network responded to congressional and veterans service organization letters in a timely manner. Selected stakeholders, who requested additional or more in-depth information, were provided additional briefings by the Network’s CARES Steering Committee.

CARES Market Area Descriptions for today’s hearing include:

The **North Coast Market** extends from the northwest coast of California below the Oregon border (excluding VISN 20’s Del Norte County) through San Francisco/Oakland and into the east bay including Contra Costa County. Highway 101 (north-south) runs the length of this market. The Bay Area presents significant transportation/access challenges due to traffic, bridges and other urban characteristics. Veterans in this Market utilize San Francisco VA Medical Center (SFVAMC), one of the Network’s two tertiary care medical centers, for acute and tertiary care and tend to rely on a large array of outpatient clinics for ambulatory care services. The North Coast Market offers a full continuum of services with two VA Nursing Homes, a Specialty Ambulatory Care Center and five CBOCs. For the purposes of CARES, this market includes northern Alameda and Contra Costa Counties, which differs from the SFVAMC Primary Service Area.

The **South Coast Market** stretches from the San Francisco Bay Area (southern San Mateo County) through the Silicon Valley, Livermore Valley, and along the coastal counties through Monterey County. The northern portions of this Market Area (San Mateo, Palo Alto and San Jose) pose significant transportation/access challenges due to traffic and congestion. This Market is largely urban and is the location of the VA Palo Alto Health Care System (VAPAHCS), one of the two tertiary Medical Centers supporting the Network. The VAPAHCS has three divisions including Palo Alto, Menlo Park and Livermore and serves a very large TRICARE population as well. The Market offers a full continuum of veteran health care services, which is further supported by two Nursing Homes, a Specialty Ambulatory Care Center and six CBOCs.

The **Pacific Islands Market** presents many geographic, transportation, and challenging health care access issues. The Market includes the State of Hawaii, which is composed of six islands (Oahu, Hawaii, Kauai, Maui, Molokai and Lanai) and four counties. Also included in the Market are the Philippines, Guam, American Samoa and several smaller Pacific Islands. It should be noted that only the Hawaiian Islands were supported by CARES data. The City of Honolulu is located on the Island of Oahu, and is the site of the VA Ambulatory Care Center, the VA Center for Aging and the Regional VBA Office, these services are co-located with Tripler Army Medical Center (TAMC). Four CBOCs are located one each on each of the larger Hawaiian Islands. Inpatient care is primarily delivered through the VA/DoD Joint Venture with TAMC. The VA also has a CBOC on Guam, where most specialty care and inpatient care is provided through a sharing agreement with Naval Hospital Guam. This Market also includes the VBA Regional Office and Outpatient Clinic in Manila. Fee basis programs further support outpatient and inpatient care in remote Pacific locations. Complex tertiary care referrals that cannot be accommodated at TAMC are referred to VAPAHCS or SFVAMC.

Network Level Planning Initiatives

▪ Seismic Deficiencies

The prime Threshold Criteria for CARES is to provide health care services to veterans, visitors and staff in a safe environment. The Network has identified correction of seismic deficiencies at SFVAMC, Palo Alto Division and Menlo Park Divisions of VAPAHCS and the Fresno VA Medical Center of VACCHCS as PIs that must be addressed. The Network has identified \$196 million in seismic correction Major and Minor construction projects, which include the three top seismic risk projects on the VA's Exceptionally High Risk listing. Correction of these seismic deficiencies is seen as the top priority in the Network.

▪ Access

Two Access PIs were identified within the Network. One was for access to tertiary care services for the Sierra Nevada Market, and the other for access to acute care (hospital) services for the South Coast Market. These PIs and solutions for these initiatives are addressed below in the individual Market Plan discussions.

▪ **Community Based Outpatient Clinics (CBOCs)**

The Network has proposed the addition of 12 new CBOCs in its Network CARES Plan. The proposed CBOCs are as follows:

- One new CBOC to address realignment - East Bay CBOC (*highest priority*)
- 11 new CBOCs to address capacity located in the following areas:
 - **California:** northern and southern San Mateo County, Lake County, Richmond, Pittsburg, Marysville/Yuba City, Susanville
 - **Nevada:** Fallon
 - **Pacific Islands:** Kaneohe and Waianae (Oahu), American Samoa (VA/DOD Joint Venture)

In addition, most Markets have proposed expansions and enhancements to established CBOCs to better meet the needs of the growing numbers of veterans seeking Primary Care and Specialty Care. As indicated above, the new East Bay CBOC, and the expansion of CBOC services in the Central Valley are critical and are our highest CBOC priority. These initiatives will directly support the effective realignment of the Livermore Campus (Division) as discussed below. The Network also feels that the establishment of the other 11 proposed new CBOCs is essential to meet the increased number of enrollees as projected through the CARES methodology. Where Primary Care Capacity Gaps exist, the individual Market Plans reflect the establishment of new CBOCs as the most significant strategy to address the gap between supply and demand. Without implementing this strategy over the next few years, the parent facilities will need to support the growth, which will further translate into increased capital expenditures. CBOCs are the preferred approach as they provide flexibility to both expand and decrease capacity (lease/contract) congruent with the changing Primary Care workload. Further, although none of the Network Markets received a Primary Care *Access* PI, many areas remain in need of improved access. In particular, these include the Pacific Islands and the remote/rural areas of northern Nevada and northern California. As such, addressing Network *Capacity* Gaps in Primary Care through establishing new CBOCs provides financial dexterity, while improving access to care for veterans in remote and rural areas of our Network.

▪ **Livermore Campus Realignment Initiative**

The Livermore Division (LVD) Realignment study is one of the Campus Realignment Initiatives proposed by the VHA Under Secretary for Health. The initiative requested analysis to determine potential for further consolidations, including converting from 24-hour, 7 days/week to 8 hours, 5-days/week operation.

The LVD of VAPAHCS, began operations in 1929 as a tuberculosis hospital. The main hospital building was constructed in the 1940s and was seismically upgraded in the 1990s. A 120-bed nursing home was opened in 1980. The former Livermore VAMC operated as an independent medical center until the mid 1990s. In 1995, Livermore VAMC was consolidated into the VAPAHCS. Today, LVD operates 15 buildings with a total of 262,000 SF located on a 113 acre campus.

The LVD serves an estimated 130,500 veterans in VAPAHCS's Central Valley catchment area. The LVD facility site is located on the outskirts of the city of Livermore in a rural region. Of the 130,599 veterans in this area, 55,000 reside in southern Alameda County. Many of the southern

Alameda County veterans experience difficulty in commuting to the LVD because of its rural location. Today, LVD operates 120 nursing home beds and 30 sub-acute/intermediate beds. In addition, the facility provides primary care and a variety of specialty care services. In FY 2002, LVD provided care to 10,400 unique patients. The facility has a staff of 301 (FTE) employees.

In response to the VHA Under Secretary for Health's CARES Realignment Initiative, the Network and VAPAHCS have developed the following realignment proposals:

- Expand Central Valley CBOC outpatient services by 35,000 SF
 - Enhance Primary Care services
 - Provide selected Specialty Care & Ancillary Services
- Relocate ambulatory care functions from LVD to a new 45,000 SF facility in the East Bay. Provide:
 - Primary Care
 - Specialty Care
 - Outpatient Procedures
 - Ancillary & diagnostic services
- Relocate LVD's 30 sub-acute/intermediate medicine beds to vacant ward space in Building 100 at Palo Alto Division
- Construct a new 200-bed gero-psychiatric/extended care nursing home at Menlo Park Division (MPD), which will incorporate 80 beds from LVD and 120 beds from a seismically deficient building at MPD. The new facility will include:
 - Dementia Unit
 - Respite Care
 - Hospice Unit
 - Extended Care
- Contract for the remaining 40 LVD Nursing Home Beds in the community.

A National CARES Project Office team, in conjunction with the Network will determine the cost effectiveness of the proposed realignment initiatives. This analysis will be complete and available for consideration prior to development of the National CARES Plan. The Network is confident that the analysis will show that the Livermore realignment proposal optimizes the use of resources by:

- Eliminating unneeded buildings from the VA inventory
- Streamlining operations and allowing reallocation of resources to direct patient care
- Reducing redundant operations and consolidating duplicative functions
- Enhanced-Use Leasing of the existing Livermore property and reinvesting revenues to support direct patient care.

▪ **Tertiary Care Proximity**

The Network is supported by two tertiary care facilities, SFVAMC and VAPAHCS. Both of these facilities are in California, located in the San Francisco Bay Area and Peninsula. These sites support the entire Network for complex tertiary care services, which spans three states with a veteran population of over 1.2 million. Both sites are recognized for their cutting-edge research programs and their significant medical school affiliations. SFVAMC is affiliated with the University of California, San Francisco; and VAPAHCS is affiliated with Stanford University.

The application of the CARES proximity criteria for tertiary care facilities (120 miles) identified SFVAMC and VAPAHCS for a Proximity PI for tertiary care services. Although the San Francisco and Palo Alto facilities are within 40 miles of each other, veteran population density and traffic patterns (1.25 hours average driving time between sites) support maintaining both sites. Present capacity makes it impossible to absorb the other facility's workload without duplicating space, and neither site can accommodate the required space necessary to integrate the facilities. Given the concentration of the veteran population in the Bay Area and distinct primary service areas served by both sites, the duplication of most subspecialty services is both necessary and appropriate. Since both sites serve as referral centers for other facilities within the Network, consolidation of most clinical programs to a single site would be impractical, given the geographic size of the Network and the veteran population. This given, the Network did carry out a comprehensive analysis of all clinical and administrative programs at both sites to identify possible program consolidations and/or realignments. The opportunities identified are primarily highly specialized, low volume, high cost clinical services, and select administrative functions. The following are recommended:

Clinical Service Consolidation/Realignment

Function	Facility "From"	Facility "To"
Long Term Inpatient Care for Dementia & Neurobehavioral Problems – Including Substance Abuse	San Francisco	Palo Alto
Electro Convulsive Therapy (ECT)	San Francisco	Palo Alto
LTC for Chronically Mentally Ill	San Francisco	Palo Alto
Certain laboratory contract testing	San Francisco	Palo Alto
Parkinson's Disease / Epilepsy Surgery / Brain Mapping	Palo Alto	San Francisco
Portions of Neurosurgery including Stereotactic Radiosurgery (Gamma Knife)	Palo Alto	San Francisco
Brain Stem Auditory Evoked Responses	Palo Alto	San Francisco
Somato Sensory Evoked Potentials	Palo Alto	San Francisco
All Surgery requiring Spinal cord and root monitoring	Palo Alto	San Francisco
Brachytherapy for Prostate Cancer	Palo Alto	San Francisco
All Dental Surgery incl. dental implantology	Palo Alto	San Francisco
Portions of radiology through increased use of PACS	Palo Alto	San Francisco
Portions of Laboratory Services	Palo Alto	San Francisco
Electronystagmographs	Palo Alto	San Francisco
Endovascular Embolism of AVM	Palo Alto	San Francisco
Moh's Surgery	Palo Alto	San Francisco

Administrative Service Consolidation/Realignment

Function	Facility "From"	Facility "To"
Reproduction/Duplicating Services	Palo Alto	San Francisco
HRM/Position Classification	Palo Alto	San Francisco
Selected Finance, Asset Management and Acquisition Operations	Palo Alto	Network Office
Warehousing Operations	San Francisco	Palo Alto
Disposal of Government Property	San Francisco	Palo Alto
Recycle Program	San Francisco	Palo Alto
Management of Transportation	San Francisco	Palo Alto
Prosthetics & Sensory Aids Purchasing Agents	San Francisco	Palo Alto
IRM Help Desk	San Francisco	Palo Alto
Police Training	San Francisco	Palo Alto

The functions identified above are opportunities that represent a total cost avoidance of \$2.37 million annually. As implementation planning progresses, efforts will be made to identify additional opportunities for consolidation, as well as to provide further fiscal/operational validation regarding the functions recommended above.

▪ **Capacity**

Capacity PIs were identified at the Market level within the Network. Outpatient Care PIs were identified in every Market, including Primary Care in five Markets, and Specialty Care in all six Markets. Inpatient Care PIs were identified in one Market for Psychiatry and Surgery. These PIs and solutions for these initiatives are addressed below in the individual Market Plan discussions.

Special Disability Programs:

The Network did not receive a PI for the Special Disability Programs analyzed for this phase of CARES. The programs included in this review are Spinal Cord Injury (SCI) and Blind Rehabilitation Center (BRC). VAPAHCS is the Network referral site for both programs. There are 43 acute staffed beds for the SCI program at VAPAHCS. The Network fully supports the SCI Program and plans on maintaining the existing program. The Network also has a 32-bed BRC at VAPAHCS, which CARES data indicates is currently not operating at full capacity. The Network received a CARES recommendation to restore the BRC to its full bed capacity. The Network will support this recommendation.

▪ **Domiciliary**

The Network operates a 100-bed Domiciliary at VAPAHCS's Menlo Park Division. This program specializes in programs for Homeless Veterans. Although Domiciliary PIs are not included in this phase of CARES, the Network will be studying the demand for this program in the near future. Currently, 58% of the Network demand for domiciliary care is being met by facilities outside of this Network, of which the majority is provided by the White City Domiciliary, located in southern Oregon (VISN 20). The Network has no plans to expand domiciliary capacity. However, as CARES operational plans are developed, this Network will work closely with VISN 20 to identify shared opportunities for addressing future domiciliary demand and capacity.