

**The following is a summary of the CARES Commission meeting and is not intended to be a complete transcript of the meeting. The information in this summary is believed, but not guaranteed, to be accurate. All information will be verified prior to issuance of the Commission's report.**

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

Full Commission Meeting  
October 14, 15 and 16, 2003  
Washington, D.C.

Review of Draft National Plan

**Commissioners in Attendance:**

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

**ADMINISTRATIVE and PREPARATORY SESSION**

**October 14, 2003**

Chairman Alvarez opened the meeting at 8:00 A.M. He announced the Commission's schedule for completing the remaining hearings. Next week he and Commissioner McCurdy will hold a hearing in Cheyenne, Wyoming and Commissioner Battaglia will lead hearings in Canandaigua, New York and Montrose, New York. He also indicated that the individual who was going to brief the Commission on the VISN 12 experience is unable to come to the meeting this week, but will be invited to next month's meeting.

Chairman Alvarez reported on his meeting with Secretary Principi last week when he and other Commissioners brought the Secretary up to date on where things stand with the Commission's review of the Draft National CARES plan. The Chairman said the Secretary accepts the reality of how things were looking. The Chairman also informed the Secretary that the Commission may not have its full report by the target date.

Vice Chairman Vogel said they discussed with the Secretary the idea of putting out a report in stages, explaining to him the need to obtain additional data to support some of the changes made in the Draft National Plan. He said the Secretary wants to move forward as soon as possible.

Mr. Larson indicated that the Commission would begin its formal deliberations at this meeting. There is no fixed schedule. There is a very large amount of information to go over that will require a lot of discussion. The law requires the discussions to be open to the public. The first two hours today will be a preparatory discussion to review the approach recommended for reviewing the materials. At 10:30, the meeting will be opened to the public. The Chairman said there has been some media interest in the meeting, too.

The agenda for today calls for the Commission to focus on ten *cross-cutting issues*. The staff has prepared a one to two-page paper for each cross-cutting issue, but what is really necessary is for the Commission to have an in-depth discussion of the issues so that the staff can learn where the Commission wants to go in each area. The plan is to get enough information about the Commission's preferences and the reasons for them that the staff can begin drafting a report after the meeting.

Tomorrow's meeting will follow a similar format. The first two hours or so will be a closed preparatory session. After that, the meeting will be opened to the public and the Commission will begin its decision "drill down" – a VISN-by-VISN review of the CARES initiatives as the staff understands them. Discussions will be supported by staff analyses of the available data.

Mr. Larson said there are two distinct universes of data to be dealt with. One set consists of the large body of data that is associated with the market plans. That data consists of historical information and won't change during the course of the Commission's review. The second set is data associated with realignment issues – the proposals included in Dr. Roswell's plan. A data call was sent to the VISNs two weeks ago asking them for data in support of the realignment proposals. The VISN responses are due October 22. Commission staff will review the data when it is received and analyze it independently. Mr. Larson said he doesn't know what is going to be in that data set or how good it will be. He hopes it will be timely.

### **Q&A/Discussion**

A Commissioner noted that a lot of the data requested is cost-benefit data and said the staff will need to have somebody available who understands fiscal data. Mr. Larson said there are people on staff who have the some background, although he isn't sure enough.

Chairman Alvarez said he hopes the data will cover the right things – e.g., vacancy rates in Manhattan and operating losses in Waco, for example.

A Commissioner said he is sure the data the Commission gets on cost won't be validated. The Commission will have to just "buy it as is." Consequently, he doesn't want to overvalue the data coming in. It will not be the case the "the light will become clear when the data arrives." The Commission will have to use a lot of common sense in dealing with the issues.

Another Commissioner agreed, but said he hopes the staff would be able to sort it out for the Commission's purposes. He also hopes the staff will be able to use it to point out any options that the Commission should consider.

One Commissioner said he is still concerned about the model. His question is whether it would make a difference in the Commission's decision-making if it had better projections from the model and suggesting more time be spent on the model.

A Commissioner said he expects the data to impact on programs, assets and costs. There should be a thorough discussion for each proposal.

Chairman Alvarez said when he and the other Commissioners talked to the Secretary about the need for better data, they pointed out that he will need to be able to go to Congress and defend all these proposals. He will need supportable data as much as everybody else.

Mr. Larson said he has assurances from VA that he can get additional resources to help analyze the financial data if that's needed. But the fact right now is that he doesn't know what he's going to get, when he's going to get it or how good it will be.

He said the Commission would have a discussion of the model tomorrow – once in closed session and again in open session. It isn't a simple issue.

After the model presentation, the Commission will get staff presentations on each issue, followed by open discussions. He emphasized that the Commission won't necessarily be making decisions at this meeting, but the staff needs to get a sense of where the Commission is coming out on the issues.

A Commissioner asked whether any voting on issues would be public. The Chairman replied that all voting is required to be public. Another Commissioner pointed out that any voting at this meeting would not be a final vote – more like a penultimate vote.

A Commissioner expressed the view that the talk about voting indicates a lot of confusion and a lack of consensus, indicating concern about what is needed and what isn't and that the work is very complex and very confusing.

Chairman Alvarez said that he is looking for consensus as to whether or not this is a good approach to Commission deliberation and decision-making. He noted the discussion will have to be somewhat general as the Commission will be dealing with issues on a national level.

A Commissioner suggested the Commission should try to bundle decisions so they will be policy-level decisions. For example, with regard to the proposed new CBOCs, the Commission recommendation might be (a) to approve only those based on access criteria, (b) to approve some based on access and some based on capacity criteria, or (c) to approve all proposed new CBOCs regardless of their basis. The Chairman said the Secretary is looking for closure. The Commission was set up as an independent body. It needs to do its job and make recommendations. A Commissioner said for him the question is whether the Commission wants to recommend a policy on CBOCs. Another Commissioner said the outcome of the CBOC issue will have a huge impact on inpatient care. It will also affect the VA's medical school affiliations. A third Commissioner said he sees the problem as one of unmet medical needs and

the question as how best to meet them. His observation has been that the further away from a hospital a CBOC is located, the more likely the patient is to use it for primary care.

Mr. Larson said this is exactly the kind of conversation he hopes the Commission will have for the rest of the day to allow the staff to capture its thinking on the issues. By the next meeting, the staff will have put the conversations from this meeting into narrative form for use in decision-making.

He also affirmed that any vote will have to be public.

In regard to CBOCs, Mr. Larson said they are not just a single issue. There are three or four major policy issues embedded in CBOCs. When the CBOCs are discussed in the public session, the Commissioners will be called on to comment based on their known interests. The rest of the Commission should then take the discussion from there.

The Chairman said he hopes the cross-cutting issue discussions will provide for broad consideration of the issues and help to avoid surprises that would be difficult to deal with later.

Mr. Larson again informed the Commission that there might be members of the press in attendance at today's session. He said there has been press interest in the meeting and reporters are likely to be in the room. He also said he would talk about more specific plans and schedules regarding report preparation in one of the later administrative sessions this week.

A Commissioner noted funding for CBOCs as an issue. The Chairman replied that funding is an implementation issue, which he considers to be beyond the Commission's purview.

A Commissioner asked about the process for getting CBOCs approved. One Commissioner said VA only has to notify Congress that they are doing it. Another Commissioner said VA put the whole process for establishing new CBOCs on "hold" pending completion of CARES. A staff member informed the Commission that the process takes 12-14 months. Discussion occurred over the t the Congressional process that involves obtaining the approval of the Appropriations Committee for proposed new CBOCs on an individual basis.

#### CBOCs as a Cross-cutting Issue

In an overview presentation on CBOCs, Commissioners were familiarized with the types of materials that would be presented in open session. Also highlighted was the absence of data documentation as a CBOC issue. The data was used to identify gaps, but the data available doesn't support the rationale used for the decisions in the Draft National Plan nor does it indicate alternatives. No real analysis has been done to support the decisions in the Plan. There is a lot of variation the data available across VISNs, so apples-to-apples comparisons aren't possible. In addition, there are some gaps between the data in the model and the data used by the VISNs.

A Commissioner said the data gaps are especially true where market projections are concerned. He said the plan uses market projections that are almost linear. Staff has spent the last two weeks trying to figure out if the data supports what is recommended in the Draft National Plan.

A Commissioner said he believes the Commission should give its own opinion on what it's appropriate to use -- whether it is demand, market share or some other measure -- for the various issues.

Staff advised that the IBM model used by VA doesn't have the capability to determine whether certain data were missing. Where there were blanks, the VISNs just cranked out data to fill them. Unfortunately, there is no way to know whether they did a good job. The analysis only provides a total figure without saying what was used to derive the total.

The validity of the model is especially called into question in rural areas, where it is unclear how it treats these smaller numbers.

A Commissioner said the data are just informative. The best way to make a decision is to use common sense. The Commission consists of 16 people who know a lot about the VA and who can do as good a good job as anybody of saying whether the decisions make sense.

A Commissioner said common sense leads to an understanding that the Commission will have to go with an interim report for now, with a more complete report coming down the road sometime. That decision was just based on a gut feeling.

A Commissioner said there are some proposals in the Draft National Plan about which he just has no idea what is the right thing to do and there are others for which important cost-benefit analysis is missing. The Commission will just have to deal with what it can.

Another Commissioner said he agrees with the approach of using common sense if that means following the "rule of reasonableness." The question is what should be the criteria for determining what is reasonable. Several Commissioners responded to the question, suggesting "quality of care," "access," and "cost-benefit" as important and possible criteria.

A Commissioner said that, for him, part of the problem is there are some external contingencies that have to occur before the plan can play out. One of these, for example, is how to free up enough space in hospitals to allow the proposed consolidations to take place.

Mr. Larson said staff has been using five criteria:

- Quality of care
- Access to care
- Cost to the government
- Economic impact on the community, and
- Impact on the mission and strategic goals.

Other criteria then suggested for consideration were (1) stakeholder views, and (2) time requirements.

Hearing testimony, reports and other documents were reviewed, in addition to analyzing the data.

Mr. Larson asked the staff to identify what is there and what is not. He noted that CARES has been advertised as a "data driven" system. The Commission can't improve the data or populate the blank spaces.

After a brief break, Chairman Alvarez said he would like to avoid taking any formal votes for now. Instead, he wants to try to get a “sense of the Commission” on the various issues.

A Commissioner asked what the Commission was trying to accomplish with the “cross-cutting issues” discussion that it has been having. Mr. Larson answered that the idea was to get the Commission’s reaction to the template that the staff is planning to use to introduce and discuss the issues. The template includes an identification of the core issue in each case, a description of the supporting information available, a presentation of the pros and cons and an identification of the options. The discussion the Commission has been having in the closed session so far has been a “dry run” of the presentation template. He would like to know whether the Commissioners feel the approach will be effective for them as a format for the public discussion.

A Commissioner observed that some gates have been created in the CARES process. They prevent discussion of how to get at the most effective way of providing health care. One example of what he means by a “gate” is the criterion that requires 7,000 enrollees for a new CBOC. He asked how the Commission should handle these.

A Commissioner said he believes the Commission should be independent. It should come up with what it thinks is needed.

Chairman Alvarez agreed. He said the NCPO put out the policy they wanted to have followed; but it is not the Commission’s task to just accept that.

Regarding the cross-cutting CBOC issue, the original CARES goals as reflected in the mini-market plans were to improve veterans access to VA health care to 70 percent. Additionally, the VISN plans used new CBOCs to address capacity issues where hospitals are out of room. The Draft National CARES Plan changed the goals. NCPO realized that establishing new CBOCs increases enrollment in their geographic area. Current VA policy is to limit new enrollment to control health care costs. This resulted in setting the limit of 7,000 enrollees as a criterion for new CBOC establishment.

A Commissioner asked whether limiting enrollment isn’t running counter to the goal of improving access. It was noted that the 7,000-enrollee criterion causes unintended consequences, both for improving access and for helping capacity.

Chairman Alvarez observed that detailed discussion of this type should be held in open session. For now, he would like the discussion to focus on issues.

The CBOC issues identified were:

- (1) VA’s current policy is that any site with a different geographic location from a VAMC hospital is defined as a CBOC.
- (2) The methodology for deciding which VISNs did and did not get new CBOCs at market level.
- (3) Leasing versus building or buying as a preferable option for establishing a new CBOC.

Issue (1) relates to the fact that several VA hospitals have planned to establish clinics in the same area as the hospital to handle workload capacity problems; however, if these facilities are just across the street, VA policy defines them as a CBOC.

Issue (2) concerns how the CBOC decisions reflected in the Draft National Plan were made and whether they were reasonable. The VISNs proposed establishing over 200 new CBOCs. The Draft National Plan proposed 48 new CBOCs as first priority or the top tier if there was an access gap, a projected increase in workload and the 7,000 veteran enrollment criterion, already discussed, was met. But the methodology used was to take a market wide average. Figures for each market area were computed on an “all or nothing” basis using the number of veterans outside the access standards divided by the number of proposed new CBOCs. VISNs who proposed a large number of new CBOCs had a harder time making the cut-off than those who proposed a small number of new CBOCs compared to enrollment. The VISNs formulated their CBOC proposals based on what they needed to close the access gap; the central office used the method identified above to prioritize those proposals.

Issue (3) concerns the proposed policy that all VA-run CBOCs should be leased. The question whether it might be preferable to buy or build.

One Commissioner said she thinks leasing makes sense. If VA buys the facilities, it is stuck there if the population moves later.

#### Critical Access Hospitals as a Cross-cutting Issue

The Critical Access Hospitals (CAH) issue falls into the “small facilities” category. The specific issue is whether the Commission should endorse the CARES Plan proposal to designate certain facilities as Critical Access Hospitals absent a definition.

There are no definite methods to designate facilities as Critical Access Hospitals -- no policy or formal definition. There is also no uniformity apparent in the proposed designations. Moreover the Medicare/Medicaid definition of CAH has not been applied uniformly in the proposed VA designations. The Plan is silent on future CAH locations. The question is how VA would decide where it would put new CAHs where there are none now. The Plan provides no data on the cost of converting a facility to a CAH, nor does it have data on quality of care. VA might have such data, but the staff hasn't seen any.

A Commissioner noted that real CAHs are located in rural areas and are the only thing out there. Reimbursement is on a “cost plus” basis. In the VA's case, it is apparent they had something in place they weren't sure how to handle, and this what they came up with. What they seem to need is some kind of flexibility to use those beds.

A Commissioner noted that Dr. Roswell, at last week's presentation, objected to paying a 25 percent premium for using community beds in areas where VA already has a facility. He said he sees nothing wrong with VA paying Medicare a 25 percent premium if that is less than the cost of operating and maintaining a VA hospital.

Another Commissioner observed that if VA is going to make a change, it needs to be a substantial change to generate any savings. He said he has seen places where the same campus,

the same buildings, the same security and other things remained the same and still had to be maintained.

A Commissioner said he believes there are areas where small hospitals are justified. He cited South Dakota as an example. It is very rural and its few community facilities are very far apart.

A Commissioner expressed the view that flexibility is needed. VHA should look at all the other costs involved, such as the cost of transporting patients back and forth, before making a decision.

Chairman Alvarez said this is exactly the kind of discussion needed. He asked about other key areas.

### Specialty Care as a Cross-cutting Issue

Specialty care, another cross-cutting issue, is how VHA decided which VISNs would get spinal cord injury (SCI) and blind rehab units.

A Commissioner said the issue for him is the difference in the plan for long-term versus acute spinal cord care.

Another Commissioner said the issue he heard was where to locate the new Center's *within* the VISNs.

A Commissioner said he would be interested in knowing how a data-driven process came up with a minimum number of beds. He also said he has trouble with the idea that an SCI bed is an SCI bed forever.

A Commissioner said VHA needs to look at the waiting lists and other information to see if it is putting in SCI beds that could be used somewhere else.

A Commissioner suggested the Commission might consider just saying that the issue needs to be re-examined if it has questions about VA policies that are arbitrary or that constrain reasonable choices.

A Commissioner said another issue for SCI is the location of the new VA hospital in Orlando rather than in the Florida Panhandle.

Chairman Alvarez ended the closed discussion at this point. He said the Commission should continue to have exactly this kind of discussion of the issues, but in open, public session.

## **PUBLIC SESSION**

**Tuesday, October 14, 2003**

Chairman Everett Alvarez, Jr., opened the meeting to the public at 10:30 A.M. Today will be the first day of a three-day session. He said the Commission has completed all but three of its public hearings on the Draft National CARES Plan and that the remaining meetings would be held in Canandaigua and Montrose, New York and Cheyenne, Wyoming next week. He noted that the Commission had conducted thirty-three hearings and made a total of sixty-eight site visits in

about two and one-half months. It is now time for the Commission to look at what it will be doing next and how it will do it.

He announced that several core issues have surfaced during the review process. These core issues are crosscutting in that they affect many if not all Networks. The Commission will deal with these issues first.

The Commission's Executive Director, Mr. Richard Larson, indicated that the first issue the Commission would deal with is Community Based Outpatient Clinics (CBOCs) and asked the staff to provide the Commission with additional information.

### CBOC Proposals and Issues

The *first issue* in regard to CBOCs is whether the strategy in the Draft National CARES Plan of establishing only 48 new CBOCs is the best approach, since 262 were recommended overall by the VISNs. There are three tiers in total. Of these, only 48 were selected for inclusion the top tier. The criteria for each of the three tiers are as follows:

*Tier One* is defined as those proposed CBOCs that had access gaps, projected workload increases *and* had more than 7,000 enrollees outside the access standard per proposed CBOC in its market area.

*Tier Two* is defined as those proposed CBOCs that have access and projected increases in workload but which had fewer than 7,000 enrollees per CBOC.

*Tier Three* is defined as those proposed CBOCs that would address capacity (workload) problems.

The original CARES goal was to resolve problems with access and capacity. It appears that a third, de facto, goal had been added by central office. According to the DNCP, this was to decrease the numbers of new enrollees that CBOCs are known to generate.

A *second issue* related to CBOCs is the current VA policy, which holds that any facility at an address that is different from the parent facility is defined as a CBOC. This definition subjects any potential new facility away from the main facility to review and approval by the VISN, by VA Central Office and by the Appropriations Committees.

A Commissioner asked whether any proposed CBOCs are "grandfathered" in. While none were some are identified as new CBOCs that have already been operating.

In response to a Commissioner's question, it was noted that there was no set criterion for the number of enrollees required to support the creation of a CBOC until the Draft National Plan was issued.

The methodology VA used when it added the third (enrollment) goal is the *third issue*. That methodology involved gathering data at the *market level*. CARES divides the total number of projected enrollees, outside the access standard, by the number of proposed new CBOCs in each market. It used an "all or nothing" formula to develop the Draft National Plan. If the result came out at less than 7,000 enrollees per proposed new CBOC, that market area got none. If it

came out at higher than 7,000, it got all. This means that the number of CBOCs the VISN proposed in each market area was a key factor in the priority decision. One Commissioner said this approach makes no sense at all to him.

The end result of this approach is that there is only one new CBOC in the top tier proposed for west of the Missouri River – a CBOC in central Washington State. Without more analysis, staff was unable to respond to a Commissioner’s inquiry as to whether this was due primarily to the low population density of these areas. Another Commissioner pointed out that the areas would also have had to have capacity gaps to qualify for a CBOC proposal.

*A fourth and final CBOC issue* is the VA’s proposal to lease space for new CBOCs rather than buy or build. This is mostly an implementation issue, but both GAO and OMB have said that leasing is more expensive. The Chairman said this is a management issue that the Commission should not address. A Commissioner said leasing is a good approach because it is quicker than getting the okay to buy or build and then going through the siting and construction process. It is also more flexible if the target population shifts.

#### Commission Discussion of CBOC Proposals and Issues

A Commissioner said he believes reality suggests the Commission should look at the number of proposed new CBOCs in places like South Dakota – rural areas where the opportunities to get medical care can be far apart and where there are large Native American populations.

A second Commissioner agreed, noting that there are eight rural CBOCs now in rural Tennessee with an average population of 2,000 enrollees. These are really just a contract-operated set of eight small clinics. They are very useful, but they would not be there under the new criteria.

A third Commissioner pointed out that the 7,000-enrollee limit is just an arbitrary management decision. The Commission can and should take a position on this matter.

Another Commissioner observed that the entire CARES process was supposed to be based on providing a full range of care for veterans. If one action truncates the outpatient piece of that full range of care, that will affect the inpatient projections. And CBOCs also generate inpatient care. He said the 7,000-enrollee limit is an arbitrary policy that upsets the whole basis of the CARES process.

Another Commissioner also said the 7,000-enrollee criterion doesn’t make sense to him, citing the variability in population density in various geographic regions of the country. He believes the Commission should recommend that VA re-examine this policy and adopt a more flexible approach to establishing new CBOCs.

One Commissioner observed that the current process for selecting sites for new CBOCs does not give any consideration to how backed up the VHA’s current facilities are. To him the most important question is not “access” but “service availability.” He thinks VHA ought to look at more factors.

A Commissioner said the Tennessee experience cited earlier indicates to her that the 7,000-enrollee limit for new CBOCs is just “bad policy.”

Another Commissioner pointed out that the more visionary VISNs have been able to do what's required without going through this whole process. They just use their current operating budgets to start new operations that address their own needs.

The Chairman observed that all of the Commissioners appear to be troubled by the 7,000-enrollee limit. There was general agreement on that observation. He then asked how the Commission wants to address the whole CBOC issue.

One Commissioner suggested the Commission should go with the full 260-plus new CBOCs as recommended by the VISNs. Questioning the basis for making such a recommendation, another Commissioner said 151 of the CBOCs on the proposed list were identified as meeting the "highest priority" standards and asked what that means. A Commissioner explained that the 151 number is the total of tiers one and two combined. They include all proposed new CBOCs *except* those designed purely to increase capacity.

A Commissioner recommended the Commission agree that "151 of the proposed CBOC locations are appropriate sites of care. They should be adequately staffed to provide a full range of services." There was general agreement on this recommendation.

The Chairman then asked whether the Commission should address the geographic discrepancies in the Plan, such as the fact that only one of the top-priority 48 clinics would be located west of the Missouri River.

A Commissioner suggested the Commission should recommend that CARES look again at proposed CBOCs in rural areas. A second Commissioner said the recommendation might want to use the term "frontier areas" because it has a specific meaning that would help to clarify the problem.

The Commissioner also said the definition of a CBOC as "anything away from the parent facility" is an obstacle to doing the right thing. Another Commissioner agreed, saying that it will be necessary to get beyond that issue for a full range of care to be addressed. A third Commissioner said he believes the ultimate decision should be data-driven, but made at the local level.

A Commissioner suggested the Commission should recommend that the CARES plan do away with the tiers and restore the full CBOC program but with the caveat that any new CBOCs must be fully staffed. Where staff is just being moved to free up space at a facility, the result shouldn't count as a CBOC. It should just be classified as a satellite operation.

Another Commissioner said that's what VA is doing now as regards satellite operations. Several other Commissioners said that was not what they heard during the field visits.

A Commissioner asked what if a VISN wanted to put several CBOCs close together. He believes they should have to justify why the CBOCs are located where they are. Another Commissioner agreed that there are some "ringers" in the package, but he doesn't feel comfortable trying to decide where all 264 CBOCs should or shouldn't be. He believes the Commission should only mention a specific proposal if it has an exception that it wants to call attention to.

A brief discussion ensued about the intent with regard to keeping the “all or nothing” formula and the 7,000-enrollee criterion. Another Commissioner said he would accept any VISN plan that would use current resources to set up in a different location. Such actions should not be considered as a “new CBOC.” The staff was asked to go to the VISNs to get a definitive list of these ‘new CBOCs.’ Another Commissioner said some proposals of that type are very clear. A Commissioner agreed that the intent in some cases is to offload capacity from the parent facility to free up space for other work and that it is essential for the VISNs to be successful in meeting their workload gaps. The Commissioner said the Commission needs to recommend a strong policy of *not* defining the movement of current resources to a new location within a reasonable proximity of where they now are as a new CBOC.

One Commissioner said VHA also might need to be thinking about moving specialty care outside the Medical Centers. Specialty care has enormous implications for capital assets. Another Commissioner said assets needed to deliver specialty care, such as laboratories, are usually associated with VA medical centers and with hospitals that have medical school affiliations. The first Commissioner noted that there are significant construction costs associated with such facilities. A third Commissioner said the Commission does not have to “reinvent the wheel.” He agrees a critical mass is needed before VA puts care in a new place. VA just has to follow the practices used throughout Medicare. The first Commissioner noted the high costs of renovations and major work associated with specialty care. He still believes VA should consider moving some specialty care outside the Medical Centers. The Commission generally agreed to include a recommendation that VA should give more consideration to placing specialty care outside of VA Medical Centers.

One Commissioner said that VA needs to consider extending hours, too. It would allow them to use what they have more effectively. Another Commissioner said when this matter was raised at the hearings, the answer was a lot of reasons why they can’t do it or the statement that they had tried it and it didn’t work. A third Commissioner, citing Portland, said she saw several examples where it is working very well. Another noted that the main point is that VA needs to be looking at ways to make better use of existing facilities. Another Commissioner said the Commission should encourage the Office of Academic Affairs to make better use of outpatient clinics. A Commissioner proposed wording along the lines of “There should be no new construction expansion until VISNs have made an attempt to meet the need by expanding hours.”

One Commissioner said in some areas where proposals didn’t make the cut, such as in VISN 23, the Commission should emphasize the need to take another look. He is especially concerned that VA look again at rural areas and their needs. Another Commissioner said VA should tighten its waiting time standards and its definitions of “emergency” and “urgent” as part of this review. A third Commissioner said he doesn’t know what the private sector standard is, but it is probably different for big cities than for rural areas.

#### Critical Access Hospital Designation Issues

Critical Access Hospitals (CAHs) are a small facility issue. The CAH model addresses access issues in rural health care. Seven VA facilities would be converted to CAHs using the HHS Centers for Medicare and Medicaid Services (CMS) model for reimbursement.

The issues for Commission consideration are the definition of a CAH and whether the Commission can endorse the CAH proposals in the Draft National CARES Plan.

The CMS guidelines specify that a CAH should be the only medical facility within a 35-mile radius. The CARES proposals for CAH designations do not uniformly meet this guideline. Other CMS guidelines are that CAHs should have no more than 15 beds, have no critical care unit, be part of a larger facility and provide 24-7 emergency coverage.

To date, VA has not established a policy or a definition of critical access hospitals for VA use. Further, the Draft National Plan is silent on the matter of where critical access hospitals should be established if there is no facility now. The Plan also does not specify performance measures for quality of care in a CAH.

The list of critical access hospitals proposed in the Draft National Plan includes Castle Point, Beckley, Cheyenne, Grand Junction, Hot Springs, Altoona, Poplar Bluff and Kerrville. Only one facility – the hospital in Hot Springs, South Dakota – meets all the CMS criteria for a CAH.

### **Commission Discussion of Critical Access Hospital Designation Issues**

One Commissioner began the discussion of the issue by saying she believes VA should get rid of the term “Critical Access Hospital” for CARES. She said it is a misnomer. VA should develop a definition for what it wants to do with small facilities, then change the language. A second Commissioner agreed, noting that VISN Directors do not know what a Critical Access Hospital is.

Another Commissioner said the facilities proposed for designation as a CAH would provide a small amount of care in relation to the cost of maintaining them. He believes that if anything significant happens the veterans they serve will just dial 911 anyway. He also asked if there was any expectation that the Commission might get a definition from VHA. The Chairman replied that he does not expect to get a definition based on Dr. Roswell’s statement the previous week that VA’s version of critical access hospitals was a “work in progress” that would evolve gradually.

One Commissioner noted that the Draft National Plan proposes to move services from Castle Point to Montrose, and then call Castle Point a Critical Access Hospital. He said this doesn’t meet anybody’s definition.

Reminded that the purpose of the crosscutting issue review is to decide how the Commission wants to deal with such issues if and when they come up in the VISN-specific discussions scheduled for later, a Commissioner said the Commission would need to look at each proposed CAH designation separately.

A Commissioner asked if there were other hospitals in the CARES “small facility” category that weren’t dealt with as Critical Access Hospitals. There are 19 small facilities in all on the CARES list, seven of which were proposed for CAH designation. The Commissioner asked what was proposed for the other 12 small facilities. He said he is looking for the reasons why the seven were selected out of the list to be CAHs. He asked if the seven proposed for CAH designation had some common characteristic and whether VA was consistent in selecting out those from the list. The other 12 small facilities are: Butler, Erie, Dublin, Ft. Wayne, Saginaw, Poplar Bluff, Muskogee, Prescott, Walla Walla, Des Moines, Knoxville and St. Cloud. No conclusion was made.

It was suggested that for this crosscutting issue the Commission should considering only the seven facilities on the CAH list. A Commissioner said that one of the facilities on the list of the other 12 would qualify for a Critical Access Hospital under the CMS criteria. When asked whether the other 12 small facilities are slated for closure, it was noted that they meet the criteria for closure.

The Chairman asked whether the Commission wants to recommend a definition of “Critical Access Hospital” in the absence of such a definition in the Plan. In regard to the proposals now in the Draft National Plan, he said there are four options for consideration:

- (a) to approve the Draft National Plan concept and the seven proposed CAH locations;
- (b) to approve certain proposed CAH locations that have supporting data;
- (c) to review all small facilities initiatives individually without regard to the Draft National Plan proposals; and
- (d) to disapprove the proposals in the Draft National Plan in total.

The Chairman asked for the views of the Commissioners as to whether it is possible for the Commission to go forward without a definition. One Commissioner said it wouldn’t be possible to approve some and not others without a definition of the concept. Another Commissioner agreed and said the Commission needs to have a rationale for acting on the proposals.

One Commissioner said his view is that the CAH proposals are a political expedient – a way to keep some small facilities open while closing others. He would prefer option “c”-- looking at all 19 small facilities individually. If there is no across-the-board definition, the Commission should evaluate all of the facilities and come up with a plan for each. He doesn’t believe the Commission should develop its own definition of a “VA Critical Access Hospital.” A second Commissioner said that the CAH concept has now been talked about in public. He thinks the Commission should ask VA to develop a definition. The first Commissioner said if VA comes forward with a proposed definition it should include the criteria for adding *new Critical Access Hospitals*. Another Commissioner said she wants to make sure the Commission maintains its flexibility to recommend keeping the facilities open.

The current consensus is that the Commission will look at all 19 small facilities individually – option “c” above – and recommend that VA come up with a definition for its own “critical access hospitals” that would include criteria for opening new ones.

### Special Disability Programs Issues

The Chairman next opened the floor for discussion of special disability programs issues – spinal cord injury (SCI) and blind rehabilitation. He said the Commissioners already know from previous discussions that the Commission agrees that SCI beds should be placed with tertiary facilities. He asked if there are any other problems the Commissioners want to highlight across-the-board and whether the Commission has the ability to evaluate the special disability proposals in the Draft National Plan.

### *Spinal Cord Injury Centers*

One Commissioner commented on the proposed facility at Jefferson Barracks, saying he didn't see the need to change it when it is working now. A second Commissioner said nobody knows where the proposal came from; it just surprised everybody. He said the proposal involves moving the patients to an area downtown known as "the war zone." It appears to be an ill-advised move.

The Chairman asked the Commissioners how they want to address special disability issues across the board.

One Commissioner said he feels strongly that when VA creates a new SCI center it has to be in a Center that provides tertiary care. The proposed new centers should be looked at VISN by VISN. He said he would also need to have more information before he could approve a new facility in Augusta.

A second Commissioner said that a broader issue for him is that the same methodology has been used in all VISNs and he is not sure it is valid. He is uncomfortable with recommending a 20-bed expansion in a hospital that can't fill the beds they have. The SCI population is going down.

Another Commissioner suggested the Commission might want to approve in principle the intent to establish new SCI centers, but noted that the Commission has reservations about their location and sizing. It might also want to take the same position on blind rehab centers. The Commission could then review the proposals on an individual basis in the VISN discussions.

A Commissioner said she feels there wasn't enough consumer input on the special disability proposals. As a result, she feels like these recommendations resulted from a "top-down" process. She believes her information is too limited to deal with the issues – she only knows what the central office wants.

One Commissioner said he does not question the new Centers in Minneapolis, the Florida Panhandle or New York. What he questions is the expansion of the existing Centers. Another Commissioner pointed out that expanding existing Centers is cheaper than building new ones. A third Commissioner observed that veterans are living longer today and there may be a need for more SCI Centers. He also noted that VA is the place to get such treatment. It is the best in the country.

One Commissioner said he saw lots of vacancies at existing SCI Centers. He said he hasn't seen data that shows unmet needs in SCI care. A second Commissioner said SCI rehab centers need to be close to home. He noted, for example, that there is nothing now west of Milwaukee. The problem is one of long distances. Another Commissioner asked if he was referring to SCI or to long-term care. The answer was "both." There is no difference in what is needed.

### *Commission Consensus on SCI*

The Chairman asked if the Commission would be comfortable agreeing in principle with the need for new SCI Centers but looking at the proposals VISN by VISN. The Commissioners indicated their agreement with this position.

One Commissioner said he does not want the Commission to get involved in operations management matters. Another Commissioner said the national issue is whether 120 new beds is the right number. A third Commissioner said another policy issue is the need for better coordination between neighboring VISNs. The Commission generally indicated agreement.

### *Blind Rehab Centers*

A Commissioner said the Plan places new Blind Rehab Centers in places that it is hard to argue with. He suggested the Commission should “concur with the location of the proposed new Blind Rehabilitation Centers and recommend that VHA conduct a thorough review of the sizing of both the existing and the new Centers to try to equalize the waiting list.”

Another Commissioner expressed the view that the Commission should recommend that VHA look at new methodologies for treating blind veterans. The first Commissioner agreed and suggested that the following be added to the statement above: “As well as other options for delivering blind care in order to impact the overall waiting list.” The Chairman determined that the Commission was in general agreement with this position on blind rehab.

A Commissioner noted there are still VISNs that have significant gaps, such as VISN 1 and VISN 12. Consequently the recommendation would not solve the problem of the large deficit. He asked if he would correct in assuming that the statement about “sizing” of facilities does not mean just “downsizing.” The answer provided was that the assumption is correct.

### **Mental Health Issues**

The Chairman indicated the next crosscutting issue to be discussed would be mental health issues.

There are two core issues in this area:

- (1) The model does not project demand, especially for long-term and outpatient mental health care; and
- (2) In the facilities considered for realignment, there is a disproportionate number proposed closing the long-term care facilities and moving patients to acute care facilities, which will put at risk the capacity to deliver long-term care.

Long-term mental health and geriatric care account for 50 percent of the current inpatient beds. The fact that the CARES demand model does not include 50 percent of the beds raises questions about its usefulness. It is not possible to get a good picture of the situation if half of the patients are excluded from the forecasting of the need. There was also a significant variation in how this was handled from one location to another.

One Commissioner noted that there is no clear distinction between long-term care, nursing home and domiciliary beds. He said he finds this confusing. The Draft National Plan just looks the other way instead of dealing with it. The population involved here is a very mixed group. It was noted that it is not possible to separate acute psychiatry from long-term psychiatry in the VA database – it’s all in the “acute care” data -- while domiciliary care is all in the “long-term care” data. Who occupies the beds is a mix of the types of patients and programs. Many patients included under extended care also have mental health diagnoses. The Commission must determine whether to consider them together or separately.

## Commission Discussion of Mental Health Issues

Commissioner McCormick had distributed a paper to the other Commissioners indicating how the outpatient and acute part of mental health can be parsed out. He said CARES treatment of outpatient mental health is flawed because VA tried to include homeless veterans and other categories in the figures when determining the gap. When taken into account, the result is a 35 percent increase in the gap.

Mental health is a big part of what VA does. Twenty-eight percent of VA patients – 468,000 veterans – have some mental health diagnosis. Primary care doctors are not comfortable dealing with these diagnoses. Three recommendations were made to take care of the mental health issue:

- (1) The outpatient CARES data should be corrected immediately.
- (2) All CBOCs authorized as part of the CARES process should include basic mental health care. They should follow the current directive unless that is not feasible.
- (3) Before any new outpatient construction or leases are approved, VHA should determine how much space is required for mental health.

A Commissioner said everyone agrees on how to fix the outpatient mental health data. This can and should be done. There is no reason to keep outpatient mental health on hold. Additionally, VA policy says all CBOCs should have a mental health component. VISNs will have to determine how big it should be at local level.

A Commissioner asked what CBOCs need to have to provide mental health care. The first Commissioner replied “a room.”

Another Commissioner said he thinks the recommendation is right on target. It solves what the Commission can solve. A third Commissioner said he likes it because it means the Commission doesn't have to wait for Milliman data.

One Commissioner also addressed acute psychiatry, e.g., for suicidal or psychotic patients. He said the current plans do not mistreat acute psychiatry. It should be easy to patch up any gaps before doing any new construction. His recommendation is the Commission should report “acute psychiatry is adequately handled by the model.”

A Commissioner agreed with the caveat that wherever possible acute psychiatry should be collocated with an acute or tertiary care facility.”

One Commissioner said long-term mental health care is still an issue and that it is messy. The best the Commission can do may be to make a policy recommendation about how to proceed in the future. He said it is hard to contract for long-term psych beds. State veterans homes are not certified for psychiatric care patients. The problem is compounded by the fact that the number one reason for a health problem being service-connected is the need for psychiatric care.

His recommendation is:

- (1) Any realignment or new construction of extended care beds must assure adequate capacity for long-term psychiatric care; and

(2) The mental health model—yet to be published—should ensure an appropriate level of extended care.

The Commissioner said the best VA facilities have the full range of services, from acute care through long-term care to domiciliary care. They can put the patient where he needs to be along this spectrum of care.

The Chairman asked whether the recommendation includes non-psychiatric nursing homes. The Commissioner said it depends on how the nursing home care beds are used. He would have to look. It was suggested that the Commission add similar language covering non-mental health nursing home beds.

The Commissioner said the other issue for nursing home beds is their location. He is not opposed to moving long-term psych beds to tertiary care campuses.

One Commissioner said he still has problems with the proposed moves included in the Draft National Plan on a VISN-by-VISN basis. He said in Ohio, for instance, the numbers don't add up for him.

A Commissioner suggested that someone should look over the implementation plans with a critical eye. Another paper had been distributed that addresses the question of the need to locate nursing home beds with medical facilities. The Plan is inconsistent in this matter. Another big issue with nursing home beds is access for families. His recommendation is:

- (1) VA must develop clear criteria for the location of nursing home beds; and
- (2) If VA proposes to move nursing home beds farther away from the population centers they serve, it should give consideration to maintaining a portion of the current beds at the current location.

The location criteria should include both quality of care and access. One Commissioner indicated agreement.

A Commissioner asked if it makes sense to move nursing home beds away from population centers in the first place. The question is if VA is going to retain some, why not retain them all. The response was that there are some locations, such as Livermore, where it makes sense to have beds in two locations. The decision doesn't have to be "either-or."

Another Commissioner said he likes the idea of a nursing home/CBOC combination. He sees it as a very economical model. A second Commissioner said some of the proposed realignments provide for retention of primary care at nursing home facilities.

One Commissioner asked about the role that state nursing homes play. The reply was that they are a very important part of the mix, recognizing their limitations (they can't handle the seriously mentally ill, particularly those needing mediations). He said he is looking to a combination of state homes, VA facilities and contracts to provide the solution.

The Chairman said he believes the Commission has a sense of direction now about how it wants to deal with this issue.

One Commissioner asked about the statement the Commission received last week from Mr. Ibson of the National Mental Health Association recommending that the Plan not go forward. He asked if the other Commissioners thought the group would accept where the Commission is

headed. It was noted that there is an intention to move away from killing the whole plan because it doesn't address mental health. The package would now place conditions on the proposals that would hopefully be acceptable to NMHA.

One Commissioner expressed the view that where patients have been in a facility for a long, long time, VA probably shouldn't move them. It was noted that a set of foster homes often develops around a facility that are an important part of care. He agreed with keeping the outpatient services and the social workers in the location with the patients in these cases. Another Commissioner said VA can't just move everybody. It needs to make allowances for distances.

In response to the question as to whether there were other crosscutting mental health issues the Commission needs to address, it was noted that the model CARES will be using for long term care is being developed without a strategic direction for geriatrics and long term mental health. Concern was raised that the model will make projections based on existing inpatient care beds and may lack a true projection of future need.

One Commissioner said he believes the Commission should recommend that the Under Secretary for Health develop a vision of future needs in this area before running the model. He said assisted living facilities have scooped up the cream of the crop of the nursing home care business. They are attractive to consumers and are not regulated. But he believes they are starting to take on borderline people who really need medical care of the type provided by nursing homes. The result is that nursing home beds are in decline at a time when the eligible population is increasing.

#### Infrastructure Integrity and Patient Safety Crosscutting Issues

The question is whether infrastructure integrity and patient safety issues should be identified as high priority for funding in the Commission's report.

The Plan includes seismic strengthening at 14 facilities at a cost of \$560.8 million. All 14 facilities project adequate workload capacity, but there is no detail as to timelines or specific improvements proposed.

One Commissioner asked if any of the proposed downsizing, realignments or changes of mission are associated with seismic facilities. The response was that Livermore and White City would be affected by the CARES proposals.

Another Commissioner asked whether the seismic projects proposed in the Draft National CARES Plan are new. The response was that many, if not most, of the seismic projects are not new. A third Commissioner said several of the seismic projects were already approved but funding was suspended until CARES was completed.

One Commissioner said he saw two buildings on his visits that were very old but where seismic improvements were proposed even though the engineer said they would never be suitable for patients again. Another Commissioner noted that some of the buildings on the list are relatively new (20 years old) but still require seismic strengthening. A Commissioner said he favors option "B" in the staff options paper.

It was noted that some seismic projects resulting from the 1988 Loma Prieta earthquake still haven't been implemented. The Federal Emergency Management Agency (FEMA) came out with new criteria two years ago. VA re-evaluated its list of seismic projects after that, so the list now reflects the changed priorities and new costs. The seismic list as maintained by the Office of Facilities Management does not take into account privacy and integrity issues and changes from CARES.

#### Commission Discussion of Infrastructure Integrity and Patient Safety Issues

A Commissioner suggested that maybe the priority should be anything with a direct patient application. A second Commissioner said he thinks the Commission should look at the seismic issue, but evaluate it VISN by VISN and market by market.

Another Commissioner said he thought the CARES process would focus on identifying where facilities are needed. He feels that decisions as to what should be funded first, which would take into account seismic improvement, are not in the Commission's bailiwick. The Chairman replied that prioritization and funding matters should not be looked at by the Commission. Instead, the Commission should indicate that "the facility isn't going away and VA should take seismic needs into account" in its planning for the facility.

A Commissioner said seismic strengthening should be a "given" in both new construction and rehabbing. A second Commissioner said patient safety has to be the highest priority. The Commission should indicate that where patient safety is involved, problems should be corrected right away, particularly where VA already has the money: \$50 million was provided and \$45 million has not been spent. Another Commissioner said that VISN Directors, when asked, indicated what their priorities are on a facility-by-facility basis. A Commissioner said that there is half a billion dollars in the FY04 budget for seismic correction. He said the Office of Construction has detailed information on what the needs are.

The Commission agreed that seismic corrections should be the highest priority for VA.

#### Enhanced Use Leasing

There are significant problems with the enhanced use process, which is slow and seemingly broken. Even so, the Draft National Plan places substantial reliance on enhanced use leasing. Enhanced use leasing is a different process from getting rid of VA property. When VA disposes of property, it goes through the General Services Administration and any money realized goes back to the U.S. Treasury, not to VA. Congress is focusing now on the agencies' handling of federal property.

#### Commission Discussion of Enhanced Use Leasing Issues

One Commissioner said he sees enhanced use leasing as an opportunity for disaster. He can foresee creating a whole new bureau to build and run golf courses, lease VA property and do similar things. Another said he isn't really sure how serious VA is about the enhanced use leasing program.

One Commissioner noted that the VA General Counsel's Office is working on establishing a trust fund that could be used to retain money from the sale of VA facilities. A second

Commissioner said he believes there are possibilities for enhancing the revenue stream, but that the total pales beside what VA is spending to maintain property.

Another Commissioner said he recognizes that the CARES plan includes a lot of proposals that would cost money and he also recognizes that VA has assets that could be used to offset those costs. But before VA decides, it needs two things. One is greater flexibility as to whether to sell or lease a property. The other is that if VA decides to go ahead with leasing, it has to have staff support in VA that can expedite the process.

One Commissioner said he believes that some VA property and facilities just have to be done away with, whether leased or not, just to get rid of it. He also agrees that the last thing he wants the Commission to do is create an entity to manage leased VA properties.

A Commissioner said this issue reminds her of the Critical Access Hospital issue. She believes any successes will be limited and not very large. She didn't see much potential for any real moneymakers.

Another Commissioner said he agrees that VA should do what it can, but he also agrees that it should get rid of properties where it can't do anything. It is important that VA stop paying to maintain properties it can't use.

One Commissioner said he believes VA should give all alternatives careful consideration before it gives away beautiful land; another Commissioner added that VA has a lot of very attractive properties. One Commissioner, while agreeing, observed that VA cannot get anybody to take the old buildings in some locations. They will continue to be a drain on the budget. In these cases, VA should just surplus the property. A second Commissioner said VA should look at how much will be saved first and also should not let any historical properties go down the drain.

A Commissioner voiced the view that enhanced use leasing, if it can be streamlined, can be of benefit to veterans. But maybe VA should consider outsourcing the process. He said the Commission should say this in its recommendations. He also agreed that in some areas VA might not be able to get any money out of a property; it should consider disposing of these. But first it should try doing the enhanced use lease process well.

A second Commissioner said all he has heard so far is that the process doesn't work. It needs to be fixed.

Another noted that historic properties will be a problem even if VA gives them to GSA for disposal.

A Commissioner said he agrees with three things he has heard so far:

- (1) the process must be improved;
- (2) the end use must have a valid impact for veterans; and
- (3) VA should consider outsourcing the process.

The addition to this as a summary of the Commission position was that, beyond this position, the Commission should consider proposals on a case-by-case basis.

One Commissioner noted VA suggested enhanced use leasing as a method of dealing with vacant space. His recommendation is that VA should not have to use medical care appropriations to maintain old, historic properties.

A Commissioner emphasized that VA needs to come to grips with whether it wants to have an enhanced use lease program. It should look carefully at the cost-benefit of retention if there is no enhanced use lease.

Also noted as a problem are the unused buildings. They are in the way. They still need power and utilities. They have to be maintained. People often suggest that these buildings could be used for homeless, for dom programs or for other uses. But the bottom line question is still where the money will come from. A Commissioner noted that it all comes from the Federal Government. Another Commissioner observed that many of the buildings just are not suitable for *any* commercial use.

The Chairman said the Commission will approach the enhanced use lease issue on a case-by-case basis, but the report will state that the Commission knows the process does not work now.

### Vacant Space Issues

The Chairman introduced the vacant space crosscutting issue.

A Commissioner stated if VA can get rid of vacant space, it should do so. He is amazed at how many vacant buildings there are and for which VISNs do not really have a reason to keep them.

Another Commissioner agreed, but said he believes the GAO claim of \$1 million a day to maintain vacant space is overstated. Staff, having reviewed the GAO reports, advised that GAO never said that VA was spending \$1 million a day to maintain vacant space. GAO went into VISN 12 after the plan was approved. When it did, it found out how difficult and expensive it can be to get rid of vacant space. What GAO did say was that VA should improve its property holdings without undue involvement of stakeholders in the process.

A Commissioner said for enhanced use leasing, the Commission should recommend deferring all proposals with case-by-case exceptions. For vacant space, the Commission should recommend option "A".

Another Commissioner agreed, saying that absent any private sector players, VISNs should drop their enhanced use leasing plans. They can always revive the plans if they get private sector interest. A third Commissioner said he thinks the Commission should say that enhanced use leasing is a good idea, but VA needs to fix the process. Commissioner said he thinks enhanced use leasing is desirable only if it involves direct benefits to veterans. Otherwise it is too difficult, expensive and time consuming. Another Commissioner said he agrees with the need to exercise stewardship of historical properties, but not with medical care money.

In relation to vacant space, one Commissioner said he is okay with option "A" but he would also like the report to say that the plan to reduce only 42 percent of vacant space over 20 years is unacceptable.

The Chairman said the Commission is agreed on the need to fix the enhanced use lease process to deal with proposals on a case-by-case basis and identify those that seem to have potential. He asked a Commissioner to work with staff to frame the recommendation.

#### VA-DoD Sharing

The plan includes a significant reliance on VA-DoD sharing but that there may be implementation issues regarding support for this collaboration. The issues are the reliability of the VA-DoD sharing plan, the nature of the DoD commitment and limited access to DoD bases.

One Commissioner noted that the Presidential Task Force on Veterans Health Care stated, “There is little disagreement on the need...what is needed is the will and the focus to implement.” This is a good chance for the two Commissions to be consistent.

A second Commissioner noted that every VA facility is a TRICARE provider, but gets almost no business from being one. The program is just a shadow of what *real* collaboration is.

Another Commissioner said he doesn’t know why it doesn’t work but he saw several places where it is obvious that it doesn’t.

One Commissioner said that in El Paso every other recommendation involves VA-DoD sharing. But the DoD players weren’t even at the hearing. He said he didn’t see any evidence of collaboration.

A Commissioner suggested the report should indicate that the Commission agrees with the concept of VA-DoD sharing but that it has yet to see the evidence of it. He noted that the main issue in this category is Nellis Air Force Base. If VA pushes ahead with its plans to abandon Nellis and push ahead with a new facility, it will be a real setback to VA-DoD collaboration.

One Commissioner said she believes that where the missions are complementary and there is a real need, collaboration will work. But she does not believe it is ever going to work on an across-the-board basis. Another Commissioner agreed, saying where there is a crisis, the people involved will make it work. Otherwise he is just not sure. He cited Biloxi as an example. A third Commissioner observed that VA and DoD are competing now in some specialties.

A Commissioner agreed with the position that the Commission should point out where there is no evidence that people are really working on collaboration. But he also believes the Commission should stress the potential.

The Chairman said the Commission’s position will be that the concept is good but the Commission is looking for substance. Where there are specific proposals in the plan, such as at Nellis, the Commission will look at those.

#### Other Issues

One Commissioner asked whether the Commission wants to address the question of the 70 percent access criterion used in the CARES process. He said during the hearings he heard all kinds of things that should get consideration in determining access, such as seasonal variations in driving time. Another Commissioner said the Commission should recognize that the 70 percent figure is just a target. There will have to be exceptions.

## Recap

The Chairman said the discussion during today's session should provide a useful framework. Over the next two days, the Commission will have to cover the specific proposals in 18 VISNs. The objective will be to identify the key points so the staff will have Commission views to work with. He said if there are areas where the Commission can't agree readily, he would ask to table the discussion for later in order not to get bogged down.

### **Wednesday, October 15, 2003: Preparatory Session**

The Wednesday morning administrative session was planned to test the format and approach for the "VISN drill down" discussions that will be held during the public sessions for the rest of today and tomorrow and to have a discussion about the presentation on the model. The Chairman said the format for the VISN reviews will be a presentation by the staff and the Commissioner(s) who chaired the hearings or made site visits, followed by a general discussion among the whole Commission. As was the case yesterday, the purpose is not to make final decisions today but to develop a sense of what the Commission sees as the main issues and where they are coming out on them.

Mr. Larson began by acknowledging the staff work that has gone into developing the data spreadsheets and detailed maps that have been provided to the Commission in support of this process. He asked that discussions begin by using VISN1 as an example.

#### Test of VISN Review Format

The review will highlight the Commission's decisions on the crosscutting issues as it goes through the VISN presentations. The review of the VISN-level issues will be from the perspective of the Draft National Plan and the perspective of the hearings, with data around those views. The Commission will need to decide whether the data are adequate.

The main issue in VISN 1 – northern New England -- is the proposed campus realignment in the East Market. The Chairman said the hearing in this VISN, in Bedford, led to confusion about the right thing to do. The Commission made additional visits.

A Commissioner reported that the hearing room was packed – mostly with older wives. The Draft National Plan calls for reducing services at this facility from 24-hours to eight hours and transferring inpatient psychiatry, nursing home and domiciliary care to other campuses. The Medical Center at Bedford is associated with Boston University. A salient feature here is that 80 percent of the families of patients live within 20 minutes of the campus and visit with patients regularly. The Plan would move the nursing home to Manchester and the dom care to Northampton. Manchester is over an hour away. After the hearing, the Commission received a large number of letters concerning this proposal, all of which had the same message: "Don't close Bedford." The Commissioner said the physical plant seen is old and unattractive and there is a staff shortage.

A related issue in this market is medical services. For years the chief VA Medical Center in this area was Jamaica Plain, which is now an outpatient facility. Inpatient services and acute tertiary care are provided at West Roxbury, which is totally inadequate for the workload it has. The

Commissioner said Brockton would be able to absorb the acute patients from Bedford, but the VISN Director does not want to break up Bedford. VA is getting ready to build a new nursing home at Bedford so it does not make sense to break up Bedford. The Commissioner believes Brockton can absorb the acute care patients and thinks VA should put a mega hospital in West Roxbury.

In response to a question, the Commissioner noted that a free-standing nursing home would be left at Bedford. Another Commissioner said there is a lot of research going on at the Bedford campus. They are able to recruit quality staff. Bedford also has an Alzheimer's unit. Overall it is one of the best geriatric units in VA. The nursing home just finished an \$8 million renovation. The Brockton facility is affiliated with Harvard for psychiatric care and Bedford is affiliated with Boston University (BU).

His view is that it would be okay to move acute care to Brockton. But it makes no sense to him to move dom care to Northampton. Nursing home care should be left alone; the nursing home is self-contained. He agrees that West Roxbury is very crowded; a 14-story tower was moved there from Jamaica Plain. West Roxbury is also affiliated with BU.

A Commissioner added that Northampton is an old facility, too. The Plan does not propose any change there.

Another Commissioner noted that the Providence Center is working very well now. It has great relations with Brown University and is an excellent hospital.

In response to a question, a Commissioner said the rationale for the proposed changes is that VA doesn't really need four facilities in the Boston area. But he said no matter what else you do it makes sense to leave the geriatric unit free standing.

A Commissioner said the central office is still pouring in money trying to upgrade West Roxbury. She views this as a waste.

#### Review of the CARES Model – Progress and Status

#### **Presentation By Mr. Thomas Mannle and Dr. Robert Burke**

Mr. Mannle reminded the Commissioners that when they last shared their findings with them, he and Dr. Burke had found the model to be reasonable for projecting enrollment, but not beyond five years, and had recommended VA do a sensitivity analysis. He said the proposed sensitivity analysis was very straightforward – a “what if” drill to hold everything constant while changing one variable to see what difference it would make to the overall result.

A Commissioner asked for an example. Mr. Mannle sketched a graph showing the enrollment rate projection curve. He said the modeling process was designed to support the Secretary's annual enrollment decision. And the process worked for that purpose – the Secretary decided to restrict enrollment. He pointed out that due to the way in which the model is structured, with the enrollment calculations being repeated monthly, the estimates of total enrollment and the projected VA market share (enrollment as a proportion of total veteran population, expressed as a percentage) get very high. This is because of the formula VA uses to determine monthly enrollment, which is:

$\text{Enrollment}_{\text{April}} = \text{VetPop} - \text{Enrollment}_{\text{March}} \times \text{enrollment rate}.$

Mr. Mannle said that as a part of the President's FY 2004 budget, announced in January 2003, policy decisions were also made to institute an annual charge for enrollment and establish a co-pay requirement for some veterans. VA assumed that the result of these policies would be to reduce enrollment.

The key question is where the enrollment rate number comes from. The answer is it comes from a 13-month period in 2000-2001. Mr. Mannle and Dr. Burke had recommended earlier that VA derive its enrollment rates from a longer period, i.e., adding additional months of data so that 30 months of data would be available to use in determining enrollment instead of the thirteen. This would have made the base more robust—less subject to error due to small month-to-month variation.

The idea of the sensitivity analysis was to ascertain the effects on total enrollment and market share if the enrollment rate tapers off. The Commission asked NCPO to re-run the model using the different enrollment rate assumptions suggested by Dr. Burke and Mr. Mannle. As of the end of FY 2002, VA market share was 24 percent; the model assumes that enrollment will rise to approximately a 40 percent level. The Commission questioned whether the proposed CARES projects would still be justified if the projected demand does not materialize as projected. The purpose of the sensitivity analysis, as recommended by the Commission's experts, was to get VA to "bound the problem" or at least to develop a lower limit so that the Commission might have some confidence in the projections.

A Commissioner observed that a lot of what the Commission is dealing with in the plans is based on projected data for the year 2012. He said he believes it is safe to say that 2012 data are reasonably reliable by virtue of being closer to the baseline year (2012 is now only eight years away).

Mr. Mannle said the sensitivity analysis would give the Commission another perspective. They were not trying to get VA to change their assumptions.

Noted was that another factor is enrollment. He said when VA builds a new facility, people enroll and begin using the system who were not using it before. Mr. Mannle said he would feel more comfortable about using that assumption if there was some analysis to support it, i.e., a VA-specific analysis of this well-known phenomenon known as the "woodwork effect" (as in, veterans coming "out of the woodwork" to use a new facility, in a way that was unanticipated). Mr. Mannle indicated that he had recently been engaged in a discussion of this same issue in VA Puget Sound, and because of the uncertainty involved, local planners indicated that current users were the most relevant basis for future planning. Dr. Burke further noted that VA overall has excellent data, including at local level but also that much of this data is not reflected in CARES-specific planning.

A Commissioner asked why VA did not use the 30-month experience as recommended. Mr. Mannle indicated that VA told him and Dr. Burke that there were two "spikes" in the data that resulted from the VA policy decisions; hence the full period of the enrollment data was deemed not suitable as the basis for deriving enrollment rates. Mr. Mannle and Dr. Burke confessed to being more than a little befuddled by that answer because there are statistical techniques

available that would allow VA to account for “outliers” –i.e., anomalous data. Mr. Mannle also indicated that a 42-month period of enrollment rate data would be available when the FY 2003 data became available sometime in November 2003.

The Commissioner asked if the model is a “static” model. Mr. Mannle answered by saying they had made recommendations as to how to go about the sensitivity analysis. Staff discussions indicated that VA was going to change the way the model treated enrollment rates. But VA decided not to do that and are now adjusting the model only to remove the constraints built in for the enrollment fee and co-pay policy decisions, and to account for migration, aging and geographic groupings.

Another Commissioner said the real issue is whether the data are adequate to make decisions. He said we know a lot about the one-quarter of all veterans who use the system but very little about the three-quarters who do not use it. The questions comes down to what kind of decisions is the Commission going to make. He said the Commission would be involved only in the decision as to whether to build. Decisions about sizing will be made later and by others. To him, the sensitivity analysis would be important where the decision is at the margin of whether or not to build.

A Commissioner said it would be helpful to have a general statement. The Commission is about to go forward with its recommendations. It will never get to the point of having perfect data.

Mr. Mannle said the key factor is the uncertainty surrounding the estimate on which all else is based. The Commission is unlikely to get that from VA, so the question becomes “what to do?” The obvious answer is to isolate those decisions that might be affected by the data issue.

The Commissioner observed that the data in the model resulted in the Planning Initiatives but the data were not used in developing solutions.

A Commissioner noted that Mr. Mannle and Dr. Burke have done what they were asked to do. He said it is now up to the Commission to apply common sense to the proposals in the Plan.

A Commissioner said the Commission should continue insisting on the sensitivity analysis. Eventually it will affect the construction decisions.

A Commissioner asked why NCPO didn’t run the sensitivity analysis and was advised that NCPO said it was because they were never directed to do it. Mr. Mannle said the charitable interpretation is that choosing not to run the model was a disingenuous act. For whatever reason, they have chosen not to run it, putting the revisions off until October for the new methodology then deciding not to change the methodology.

Dr. Burke said the NCPO ran another model and called that a sensitivity analysis. Mr. Mannle added that VA has said they understand there is a high-priority need to look at the impact of enrollment data on market share. They want a more dynamic model for use in the planning cycle.

A Commissioner asked if the model analysis includes any confidence intervals at all. Mr. Mannle answered “no.” He asked if they made any attempt to develop confidence intervals and

Mr. Mannle said he had not seen any. He added that if VA wants to treat the issue seriously, they have to have somebody else – not Milliman or the staff – take a look at it.

A Commissioner said his recommendation would be that the current data are adequate to the decisions that the Commission has to make. This is partly because decisions about the sizing of facilities can be made later. The Commission should also strongly recommend that a sensitivity analysis be done so that it will be available when the sizing decisions have to be made.

The Chairman ended the closed session of the Commission at this point.

**Wednesday, October 15, 2003**  
**Public Session**

The Chairman opened the public session, announcing that the first order of business would be consideration of the last of the cross-cutting issues: the CARES model. He introduced the Commission's contract staff experts on the model, Mr. Thomas Mannle and Dr. Robert Burke, and asked them to provide a brief update on the status of the model.

Mr. Mannle informed the Commission that VA and Milliman had produced several changes to the model used to make demand projections for the CARES process. He and Dr. Burke looked at a few of these changes, including the addition of migration data, new veteran morbidity and mortality assumptions, corrections for under-representation of rural areas and the removal of policy assumptions about the effects of enrollment fees and higher co-pays and deductibles. He said as a result of making these changes, enrollment has changed.

Mr. Mannle said he and Dr. Burke had recommended looking at a longer base period of time, using 30 months worth of data instead of 12. They had also recommended conducting sensitivity analysis to get a lower boundary of enrollment numbers.

Mr. Mannle and Dr. Burke reviewed an updated result at the end of September. Their conclusion is that the enrollment methodology used for the CARES model has not changed. As a result of the changes VA and Milliman did make, enrollment estimates are now different – they are higher. He and Dr. Burke continue to believe there is a need for sensitivity analysis. He believes the Commission may need this for decisions that are dependent on future enrollment.

The Commission was reminded that at an earlier meeting it had decided the model was adequate but that the Commission had reservations about some of the data used and had requested that VA conduct sensitivity analysis. This was not done.

Chairman Alvarez said he believes there is a significant need for additional analysis related to major capital investments and said he still wants to see changes in the model. The Chairman then opened the subject for discussion by the Commission.

One Commissioner said the Commission's role is to come up with a judgment on the reasonableness of the proposals. For actual decision-making on what to build and where to build it, VA should conduct the sensitivity analysis in order to inform its decision-making. A second Commissioner agreed, saying that the Commission would have to look at the reasonableness of the available data to make decisions now. But VA will need better data later on for final

decisions related to location, sizing and other matters. A third Commissioner said the difficulty of dealing with the out years argues for the need to contract more decision analysis.

A Commissioner asked whether the Commission had made a formal request to VA for a sensitivity analysis. The Executive Director, Mr. Larson, said the Commission made the decision at its June meeting that sensitivity analysis was needed and that decision was communicated to VA. The Chairman said he and the staff certainly believed that sensitivity analysis had begun. He said again that he still feels there is a need to go through with it because it will be important in looking at the long-term recommendations.

One Commissioner noted that the Draft National Plan often deals with veterans who have limited access. He said he is upset that the decision was made to remove the \$250 enrollment fee and higher co-pay requirements. He believes these factors could make millions of dollars worth of difference and he believes Congress needs to see this. A second Commissioner pointed out that Commission may already have the figures on how much difference these factors make in their report from Mr. Mannle and Dr. Burke. Their report shows the impact of the broad policy decisions on the model as a whole. The first Commissioner said the report does not show the impact on the creation of CBOCs, the number of new beds needed, and similar issues. The second Commissioner said the numbers provided by Mr. Mannle and Dr. Burke are a “roll up” and that the Commission can get at the underlying detail.

The same Commissioner said he is confident that the Commission will come up with a way to proceed. However, he is uncomfortable with the fact that VA didn’t respond to the Commission’s recommendations. He isn’t clear on how to make sure that happens. The Commission is proceeding as best it can given the circumstances, but the people in VHA are making the job difficult by not cooperating.

The Chairman said the Commission appears to agree on the option that calls for accepting the model but continuing to ask for a sensitivity analysis. The Commission agreed.

Mr. Larson announced that the Commission has now concluded its discussion of crosscutting issues. He said the staff will produce revised position papers for the Commission in the next week to ten days.

### **Individual VISN Reviews**

Mr. Larson next introduced the VISN “drill down” reviews. He said the purpose is to get a sense of where the Commission stands on the Draft National Plan proposals and issues in each VISN. The format for the discussion will be for the staff and the Commissioners who chaired the hearings or conducted site visits in each VISN to make a presentation of the proposals and issues followed by a general discussion by the whole Commission.

### **VISN 1 – Maine, New Hampshire, Vermont, Massachusetts, Rhode Island, Connecticut**

#### **Presentation of Data and Issues**

The review of VISN 1 began by discussing the information included in the Commission’s briefing book. The data presented are primarily the same data the VISNs used to develop the

market plans, but it has been tailored to focus on the Draft National Plan. The Commission was reminded that not all of the VISN market plans made it into the Draft National Plan.

The principal issue in VISN 1 is the proposed realignment of campuses in the East Market (eastern Massachusetts and Rhode Island). The realignment involves transferring patients from the Bedford, Massachusetts, facility to five other VA Medical Centers within VISN 1. There are also other issues involved with inpatient and outpatient care.

All areas in VISN 1 have outpatient gaps. The main issue is workload. The staff looked at the workload gaps and space projections. Workload demand in the VISN is growing, although the growth is small in some areas. There are also space deficiencies.

One Commissioner asked where he could find the actual data, since the data were not included in the Commission's briefing books because of the volume. Another Commissioner suggested the Commission could use the "scorecards" that were developed earlier.

In response to his question, the Chairman was advised that additional data been requested in the data call that went out earlier, but which has not yet been received, include workload projections, space projections and cost-benefit analyses. A lot of data were requested – the request totaled 34 pages. One of the difficulties was the varying degree of sophistication in data across the different VISNs.

On outpatient issues, it was suggested that the projected workload was adequate and the space management projections were sufficient to support the recommendations to establish and expand CBOCs. The requests seem reasonable, although none of them made the VA's top priority tier. There are some proposals in the second priority tier, mostly in Maine, which is sparsely populated and very rural.

A Commissioner said that when the Commissioners started discussing the proposed CBOCs at the hearings, the VISN Directors indicated they have priorities. They would accept less than all of the CBOCs proposed and they know where they want them. He suggested maybe the Commission should look at the CBOC proposals again based on VISN priority assessments.

One Commissioner said he sees logic to focusing the new CBOCs in Maine. There are some small ones there now and the percentage of category eight workload in this market is much lower than the national average. He said this is something you see in rural areas. The largest access gaps are in Maine. The proposed CBOCs there are likely to be small and will target high-priority veterans. He said he believes the Commission should go with the Network's recommendations because the proposal meets the access gap. The Commission should defer to the Network's judgment. A second Commissioner asked how many CBOCs the VISN has in Maine now. The answer provided was six, with the largest in Bangor.

### Procedural Discussion

As a procedural matter, one Commissioner asked if the staff could post a list of the decisions made by the Commission yesterday on crosscutting issues. She said she wants to be able to see those decisions and be cognizant of them as the Commission works its way through the VISN-level proposals. Mr. Larson said the staff was in the process of preparing and distributing a list, but that it had not been vetted with the Commission. Regarding the earlier request for data, Mr.

Larson said he is hoping the Commission can have a dialogue about the proposals without going into a detailed review of the data. He would like to get a “sense of the Commission” in narrative terms. The staff will then review data regarding that set of narrative concerns. His concern is that if the Commission begins to delve into the data, the discussion for each VISN might require up to a full day – time the Commission does not have. He promised the Commission the staff would have specific data available for the next iteration.

Greater detail was provided regarding some of the “soft” terms being used, such as “relatively stable,” “slight increase,” “sizable” and similar terms. The data behind these are subject to change when the VISNs respond to the new data call. Actual data will be inserted as soon as it becomes available. In this particular VISN, the new data provided to the staff may be inadequate because of the shifts associated with the proposed realignments. Chairman Alvarez said he wants to give the staff a chance to determine whether data supports Commission’s views.

The data in VISN 1 appears to support the VISN CBOC proposals although the realignment proposals might affect the VISN recommendations.

A Commissioner asked whether the Commission’s final recommendations would be specific, i.e., at the individual facility level as opposed to the VISN level. Chairman Alvarez replied that recommendations would have to be at the specific facility level in some cases, citing Boston area facilities recommendations as an example. However, where the Commission can handle an issue on a VISN-wide basis, it ought to do so.

A Commissioner said the Commission only has enough information to come up with general directions to the staff. The Commission should focus on doing that, identifying what it doesn’t know now that it needs to know before it can make a final decision. The Commission should put its staff to work getting *that* information. Another Commissioner said he wants to look at VISN-level work unless there is a significant disparity in the Draft National Plan. When there is a disparity, the Commission should check that out. For the most part, he does not want the Commission to get involved in VISN decisions.

One Commissioner observed that if the Commission just goes with the VISN Market Plans on CBOCs, it wouldn’t be making any tough calls, but rather only be shooting the VA budget way up. He asked what the Commission will have accomplished if that’s all it does. A second Commissioner replied that VA would have to decide what’s affordable at the implementation stage. Another Commissioner said that the Draft National Plan methodology was so rigid that it restricted making reasonable decisions.

A Commissioner said the right answer in Maine, from his viewpoint, is to open the six small CBOCs and tell Togus to pay for it. The Government way is to put the six CBOCs on a list and try to get Congress to pay for them. A Commissioner responded that with only one new CBOC west of the Missouri, Congress will want to weigh in on the issue.

Another Commissioner said it is likely the implementation methodology will be just as restrictive as the planning methodology. There will only be so much money available.

A Commissioner said if 234 new CBOCs are needed, the Commission should endorse that many and put in an incentive for the VISNs to do them within their existing resources. Otherwise, the Commission is just throwing them all back on the table.

One Commissioner pointed out that VA established the 600 CBOCs it now has using its own resources. He suggested that VA will get to the point where it can only do so many through internal efficiencies. Then they will have to ask Congress for money to do more. A second Commissioner said he believes VA should encourage people to go ahead and do it. The principle should be to “use forgiveness rather than require permission.” A third Commissioner agreed, saying he would like to see the shackles removed from the people in the field and allow them to set up CBOCs without permission.

One Commissioner said he would recommend that the guidance to the staff should be to lift the “7,000-enrollee” parameter. Look again at access. Identify what is needed to get to the 70 percent level, which is reasonable in the Commission’s view. The VISNs should be able to do that.

One Commissioner said she believes the Commission needs to have a session on how to encourage management to get them to do the things that are needed, such as lifting the burden from the field. They also need to recognize and reward creativity and innovation.

On the CBOC proposals in other VISNs, it will be noted where it is not clear that the data supported the proposals.

#### Resumption of VISN1 Discussion

The next subject introduced was “inpatient care.” This is another area where the staff will look at the campus realignment to see how it impacts inpatient care. For example, Togus – the only facility in Maine – needs some expansion now and may need more under the campus realignment proposal. It was suggested that the recommendation is reasonable.

A Commissioner asked if there was a VA Medical and Regional Office Center (VAMROC) at Togus – i.e., a centralized management of services. The response was that there is not – Togus health care services and benefit services remain collocated but they are now under different leadership teams. Another Commissioner asked if VA Regional Offices will be leaving the campuses under the Draft National CARES Plan. He said this would be the opposite of what it said it was trying to do. The answer given was that Regional Offices will not be leaving. The “one VA” concept has not been hurt.

A Commissioner said he would like to hear from the Commissioners who visited the VISN what they heard and what discrepancies they see in the Draft National CARES Plan.

One of these Commissioners spoke for the Commissioners who attended the Bedford hearing, saying that those Commissioners who visited there are not in agreement with the proposals for the Bedford facility included in the Draft National Plan. The Draft National Plan calls for converting the Bedford facility to an 8-hour operation and moving the nursing home to Manchester. Most of the veterans at that facility live within 20 minutes of it. Their families are active and regular visitors. Manchester is at least an hour away and more in winter. Additionally, Bedford has a very powerful geriatric program. Closing the facility there would likely cause the VA to lose its affiliation with Boston University, which is unlikely to move to Manchester with the VA program. The Draft National Plan also proposes to move the homeless veterans to Northampton. This move would accomplish nothing. The facility at Brockton

believes it can accommodate the overflow of Bedford patients. The bottom line is that VA management at Bedford was stunned by the proposal included in the Draft National Plan. The Commissioner said the Commissioners who visited could not buy into the Bedford proposals at all. The nursing homes there are both social and medical models. The Commission has received tons of very persuasive letters supporting Bedford.

One Commissioner pointed out that Bedford is not going to fall down. The proposed closure is just a matter of principle. A second Commissioner said the potential for financial savings drove the decision. But the Commission does not have financial cost-benefit data, so it can't make a final decision on this issue. He said the Network staff is not projecting a substantial benefit from the change. He believes any financial benefit will be outweighed by the quality of care. He agrees that the nursing home should stay in Bedford under any circumstances. He also said the geriatric program should stay in Bedford. The most that should move to Manchester is long-term care. But he is still waiting on data about the rest of the proposal in the Draft National Plan.

A Commissioner said the other programs at Bedford are housed in ugly, outdated facilities. The Brockton facility is beautiful and new and would serve well.

The Draft National Plan also recommends improvements to the inpatient facility at Newington, but there is no data to support the proposal.

#### Sense of the Commission

The Vice Chairman, acting for the Chairman, said the Commission agrees that there is a collocation issue to be resolved in VISN 1, although it appears that VA might be able to reduce the footprint at Bedford.

#### **VISN 5 – Metropolitan D.C., Maryland and the West Virginia Panhandle**

The Commission, with Vice Chairman Vogel presiding, asked that initiatives and issues be highlighted, then followed by input from the Commissioners who were at the site visits and hearings. He began the discussion by noting that VISN 5 has three hospitals: Martinsburg and Morgantown, West Virginia and Baltimore-Washington.

#### Presentation of Data and Issues

The key initiatives in VISN 5 concern outpatient care services in primary care and mental health and joint ventures with the Department of Defense at Fort Meade, Fort Detrick and Fort Belvoir. There is also an enhanced use lease proposal for the Perry Point facility.

A Commissioner described the VISN 5 proposals. One would redesign the Perry Point campus to increase its enhanced use lease potential. He said Perry Point is a vastly underutilized campus. There is a lot of potentially valuable property there, but it is in disrepair. The psychiatric care facility is new. The big issue is nursing care. That facility is not up to par – it is not air-conditioned and needs remodeling. VHA wants to do an enhanced use lease there to put in an assisted living facility. The Commissioner said Senator Mikulski is opposed to an enhanced use lease at Perry Point; she wants to see what happens at Fort Howard first. VA has not provided any detail regarding the enhanced use lease proposal at Perry Point. Right now it is only a vague

concept. He said it is a beautiful spot; VA may not be ready to give it up if it doesn't get an enhanced use lease.

In regard to Fort Howard, the Commissioner said there is an enhanced use lease project underway there now and it looks like it will happen.

The Draft National Plan proposes to move 77 domiciliary beds from Martinsburg, which is primarily a detox program, to DC. A private developer will put 300 beds at Martinsburg for transitional housing for the military; VA will then take over 77 of those beds.

A Commissioner said a lot of the dom patients in Martinsburg are from Washington, DC or Baltimore. He said VA needs more beds in the cities. The buildings at Martinsburg are old. This seems to him to be a well thought out initiative.

The Commissioner also outlined the planned VA-DoD joint venture collaborations at Fort Detrick, Fort Meade and Fort Belvoir. He said access will be a problem at all three facilities due to the nature of their missions. Another problem has also arisen at Fort Belvoir. VA and DoD had worked out an agreement in writing but the new commander disavowed the agreement.

The Commissioner completed his summary of VISN 5 by noting that the Draft National Plan also proposes some new construction for Washington, including an inpatient psych ward and a new parking structure. One problem is that the parking structure has to come from a different pot of money than the medical facilities.

### Commission Discussion

One Commissioner asked whether any acute care beds would be left in Baltimore after the move of 22 beds to Washington, D.C. The answer given was "no."

A Commissioner said if the Commission gets the data it needs, the proposals seem reasonable. The only issue was the willingness of physicians to go to outpatient clinics in Maryland if VA can't get the inpatient expansion. But there are no "show stoppers." The Commission just needs some more meat on the table before it can make final decisions.

One Commissioner commented that if VA would do its training in outpatient clinics, physicians would be willing to go there and work.

There is a need for supporting data, but said the Commission won't be getting any more from this VISN because there is no consolidation proposed in the Network.

Also noted was that the proposed new Baltimore CBOC is a third tier clinic involving expansion of primary care capacity, which is different from the other proposals.

The Vice Chairman pointed out that the Commission has already decided that if a Center moves capacity down the street, that's not a new CBOC. It just improves throughput.

A Commissioner asked about extended hours at Glen Burnie. Another Commissioner said he is comfortable with the proposed movement of domiciliary beds and that the impact on the budget would be low.

### Sense of the Commission

A Commissioner summarized the recommendations in this VISN. Overall, the approach is reasonable and the proposals satisfy the Planning Initiatives – the concepts meet the criteria. The only problems are with the enhanced use lease proposal and with access to DoD facilities where there is proposed collaboration.

### **VISN 6 – North Carolina, Virginia, Part of West Virginia**

#### Presentation of Data and Issues

The Commissioner who led the presentation on VISN 6 began by noting that the VISN includes eight VA hospitals and several major military bases (Newport News, Fort Bragg and Camp Lejeune, for example). He highlighted several items that will require the Commission's attention.

One concern is *CBOCs*. In the *Northwest Market* – the area near Lynchburg, Virginia and southern West Virginia – three CBOCs were requested that were not included in the Draft National Plan. The region is mostly rural and mountainous. In the *Southeast Market* – around Durham, North Carolina – seven new CBOCs were proposed by the VISN, none of which are in the high priority group. The Commissioner said this market is a good example of how the formula used for the Draft National Plan sliced things up and did not come up with the right answer. In the *Southwest Market* – the Charlotte, North Carolina area – six new CBOCs were proposed, all of which met the requirements for priority consideration in the plan under the formula. The Commissioner also said this example shows how the formula worked in one place but not in another. He said if the VISN had requested fewer CBOCs in the Southeast Market the proposal might have been approved. The Commissioner noted that in Durham the VISN wants to move primary care out of the hospital to make room for specialty care, but they can't do it because it would amount to establishing a CBOC.

Another issue that will require Commission attention is the *proposed Critical Access Hospital at Beckley, West Virginia*. The hospital was originally on the small facility list but the Draft National Plan makes it into a Critical Access Hospital. The Commissioner said the people in the area value the hospital and do not want its services pared back.

A Commissioner said he was impressed by the Beckley facility. It is very well maintained. They are currently converting the atrium there for patient care. Local constituents told the Commissioners that there really is nothing else available in Beckley for veterans to use. He also said local management has been aggressive about enhancing patient care on their own initiative. Additionally, Beckley just got Congressional approval for a new nursing home.

The Commission was advised that Congress had authorized the nursing home but the money has not been appropriated yet.

#### Discussion of Beckley Hospital

The Vice Chairman said a question has been raised about how to test the local facilities and their adequacy in this case.

One Commissioner commented that VA has only twenty patients at this facility. He asked on which small hospitals would the Commission be aggressive. He said it is normal that people will try to hang on to what they have.

A Commissioner noted that low volume would indicate that the facility will have a hard time maintaining quality. Another noted there is strong Congressional interest in this hospital.

In response to a question as to where patients in this area normally go for other treatment, it was said that they go to Richmond or Durham for major surgery and some go to Salem for minor surgery.

#### Continuation of VISN 6 Presentation

The Commissioner briefing the Commission said VA hasn't been able to even get a foot in the door at Fort Bragg. He said this a DoD collaboration issue, but there is no specific proposal before the Commission.

The Commissioner indicated there is an enhanced use lease pending in Durham that would develop part of the property for non-VA use. He said this project is a prime example of the problems with the enhanced use lease process. There was agreement, noting that two years is a long time to wait for something that both parties want.

The Commissioner said the hearings suggested that the affiliates would like to put more people out in the clinical sites.

#### Specialty Care Discussion

The Vice Chair noted that an issue regarding specialty care in the VISN had been brought to the Commission's attention.

Hampton has long-term SCI care and Richmond provides acute care. Hampton people tend to stay there once they get in. There has been no problem at Richmond.

A Commissioner said if there is no difference between an acute care bed and a long-term SCI bed, he doesn't see where there is a problem.

The Vice Chairman said there is no proposal in the Draft National Plan about this, but the issue was raised.

#### Additional Discussion of the Beckley CAH Proposal

One Commissioner said if the VA is going to have a hospital in Beckley, there are probably 30 other places like it that should also have one. He said he agrees with one Commissioner's point about having criteria that would address establishing new critical access hospitals where there are none now.

Another Commissioner said the Beckley VISN Director claims they are unable to get their veterans into other hospitals, however, the VISN did not provide any data to support that claim, nor did it provide data on performance or quality of care.

A Commissioner said the Commission has data. Beckley has 20 patients and the bed days of care will be 50 percent of the current number by 2022. The standard is 40-beds by 2022 is the cut-off point for identifying small facilities. Another Commissioner agreed that the occupancy rate just isn't there to justify keeping the facility open.

Several Commissioners had a general discussion about the facility's use for nursing home care. Some while back the bed tower was converted to nursing home use and VA is now building a new nursing home at the location The Market Plan called for more beds in the current nursing home. The Draft National Plan characterizes these as a "replacement." The nursing home is a 60-bed facility and it is still not clear what VA will do there. One Commissioner said the local stakeholders are dissatisfied with the facility. He said more would use it if there were a better nursing home there.

One Commissioner said he could not recommend retaining a small facility at Beckley. Another suggested putting the matter up for further study. A third said the Commission should at least get data on community availability.

One Commissioner said the issue is how to take care of those 16 patients. He suggested the model to use could be the CBOC/nursing home care model. The alternative looked at by the VISN was simply shutting down the surgery beds – there is only one. A Commissioner pointed out that the workload is projected to continue dropping – 30 percent by 2022.

#### Sense of the Commission

The Commission discussed to the following with regard to Beckley – VISN 6:

- Keep the long-term care beds.
- Schedule the small facility for phase out, not conversion to a CAH.
- Retain the primary care and what specialty care Beckley has now.
- Retain the ambulatory care facility for inpatients.

### **VISN 7 – South Carolina, Georgia, Alabama**

#### Presentation of Data and Issues

A Commissioner who presented the information on this VISN began by noting there are tertiary facilities in all three states – South Carolina, Georgia and Alabama. He described these hospitals as being "landlocked" facilities. VA is trying to free up space in these tertiary facilities by increasing the number of outpatient facilities.

The Draft National Plan calls for closing the small VA hospitals in Montgomery, Alabama and Dublin, Georgia while retaining a VA presence in each location. He said the stakeholders – and one stakeholder in particular – are arguing to keep the facilities open.

The Plan for this VISN includes 15 new CBOCs, which are well supported.

The Plan also adds new inpatient capacity at Huntsville, Alabama through contracting at local facilities.

The VISN is also thinking about adding new CBOCs to serve the Florida Panhandle.

The Commissioner said a plan to convert the two-division Augusta medical center to an eight-hour operation was squelched, however the Commission reviewed the data.

There is data available to support the Draft National Plan for this VISN in regard to “access” in this VISN. The VISN did its own study in Birmingham consisting of population studies. All of the new CBOCs listed are intended to resolve access issues. The VISN will expand its community contract work to accommodate projected workload increases. The VISN also has a number of proposals to transfer workload out of facilities to free up space to meet specialty care needs.

#### Commission Discussion

One Commissioner asked about plans to handle the growth in mental health care demand in South Carolina. The VISN has a plan to contract with the Greenville Hospital for inpatient mental health in that part of South Carolina.

It was confirmed that the new CBOCs would have mental health care services. Several Commissioners held a brief discussion about the difference between what the Draft National Plan calls for in Montgomery versus the original VISN plans. The proposal was to convert Montgomery to an outpatient facility and close the rest. The Draft National Plan calls for further study of this proposal. The Commission would be getting more data on this proposal.

One Commissioner said Montgomery and Tuskegee have been under single management. There have been lots of medical and surgical consolidations.

#### Montgomery Realignment-- Sense of the Commission

After asking for additional comments, the Vice Chairman said the Commission agrees with the Draft National Plan proposal to conduct further study in Montgomery.

#### Augusta, Georgia, Discussion and Sense of the Commission

The Vice Chairman began the discussion of the Augusta, Georgia facility by noting that the Plan once called for closing it, then changed to studying closure and now takes the facility off the table altogether. The uptown facility in Augusta has a lot of unoccupied space. It is a large facility with small occupancy.

The Vice Chairman said the issue in Augusta is whether VA needs two facilities in one town.

It was noted that the two facilities are eight miles – eighteen minutes – apart, with a need to offload primary care from the hospital and place it in some other place.

One Commissioner said he liked the proposal to study alternative approaches to providing care in the area. A second Commissioner asked whether all two-division hospitals other than Augusta are on the realignment list. If so, he thinks VA should look at Augusta again. Another

Commissioner agreed, saying he questions the need to have two 24-hour facilities that close together.

Further discussion indicated that the downtown Augusta facility is full to capacity. Traditional hospital services are not provided at the uptown facility.

Following the discussion above, the Commission showed agreement that the Augusta facility does not need further study. The Commission agrees with moving primary care to the uptown facility. VA should give attention to getting rid of the vacant space.

#### Dublin Discussion and Sense of the Commission

The next item discussed was the small facility in Dublin, Georgia. The Draft National Plan proposes to retain the inpatient program there but review the other programs.

After a discussion, the sense of the Commission is that VA should contract out inpatient medicine and surgery at Dublin but keep the nursing home and domiciliary.

#### VISN 7 Spinal Cord Injury Center Discussion and Sense of the Commission

The staff said the Draft National Plan includes new spinal cord injury (SCI) beds in VISN 7. The VISN did extensive analysis of the projected needs and capabilities. Community resources just do not exist.

One Commissioner said he would recommend approving this proposal in concept subject to additional data analysis before implementation.

Another Commission noted that the Draft National Plan proposes to add 20 SCI beds now. He asked whether the Commission should change the recommendation to 2012. It was noted that construction projects in the past year account for the low SCI census.

After further discussion, it was determined that the sense of the Commission is to increase the SCI beds in VISN 7 over the next three or four years, then look again at the demand projections. The Commission also agrees with adding 11 beds now if the data shows a projected gap over time.

### **VISN 4 – Pennsylvania, Delaware, West Virginia (Part)**

#### Presentation of Data and Issues

The Commissioner who initiated the discussion of VISN 4 said there are two markets in the VISN – Philadelphia and Pittsburgh. He also noted that issues were raised about the lack of inter-VISN cooperation on SCI services.

The principal thing the Draft National Plan deals with in this VISN are small hospitals. There are several in the West Market – Butler, Erie and Altoona – but none in the East Market. He said the Commission visited Butler and Pittsburgh.

#### Butler Discussion and Sense of the Commission

One Commissioner reported on the visit to Butler, stating that there was only one patient there when they visited and he left while they were there. The Draft National Plan proposes to close its hospital acute care services but keep its nursing home and outpatient services. The facility could contract its long-term care to Butler Memorial. The community hospital in the area is well used. It has outgrown its current facility and would like to move to the VA grounds. VA is exploring this and other enhanced use lease possibilities at Butler. Concern was raised about the time that would be required to approve an enhanced use lease for the site.

Butler is only 35 miles from Pittsburgh. Its inpatient operation is not viable. Additionally, a lot of emergency care is available in the area. In addition, the facility has a fine rehab unit that needs to be maintained.

One Commissioner asked about stakeholder views. It was noted that they didn't get a lot of input. The stakeholders seemed more concerned about getting new CBOCs in the western Pennsylvania mountains.

A Commissioner said this seems like an ideal place for an enhanced use lease if the enhanced use leasing process worked, stating that the community hospital there has a good reputation. There was agreement that it would be an ideal opportunity.

In response to a question, it was noted that Butler is *not* proposed for conversion to a critical access hospital.

The sense of the Commission was to agree with the Draft National Plan proposal to close the acute care unit, keep the rest of the services open and seek an enhanced use lease with the community hospital.

#### Erie Discussion and Sense of the Commission

The other facility in this VISN that requires Commission discussion is the small facility at Erie.

The Draft National Plan proposes to retain inpatient medicine and close inpatient surgery. The workload at this hospital is very low now and projected to decline. Another Commissioner noted that the hospital does not do enough surgery to meet the standard of care. A third Commissioner noted that if VA closes the surgery unit here it will either have to send those patients to Pittsburgh, which is a long way, or contract for their services.

One Commissioner asked what VHA would need to retain by way of infrastructure for medicine beds and whether VA would need the diagnostic activities. The response was that is a management decision. The Commissioner asked how big the hospital is and whether VA would eventually phase it out. The reply was that the proposal did not involve phasing out the medicine beds.

Another Commissioner, in reply to a question, was told there are good community alternatives available in Erie. A Commissioner noted that he does not see much difference between Erie and Beckley except there is more alternative care available in Erie. A Commissioner observed that the workload is stable but declining.

One Commissioner asked why, if the facility is too small to do surgery, it would keep patients that are more complicated – the internal medicine patients. He said the complexity of internal medicine is greater. If VA closes one service, it should not keep the other.

Asked for a comparison of the “ABCs” at Beckley and Erie, the staff replied they were at least comparable about the same. A Commissioner asked for internal data on Erie by bed section, plus the same external data as for Erie. Another Commissioner said the issue in Beckley was “quality.” The Commission agreed that the proposal shouldn’t move forward if veterans can’t get quality care in the community.

Chairman Alvarez agreed. He said the key question is whether the services needed are available in the community. He asked the staff to verify the availability of alternative community care at Erie before making a final Commission decision. The Commission intends to deal with Erie the same way it deals with Beckley.

One Commissioner said the approach should be to look at the key data at facility level – enrollment growth, capacity of community hospitals and similar data. Make sure that the facility review is comparable to Beckley. His view is that if the plan proposes to build something new, then 2022 data are more important. If proposing to close, the 2012 data are more important – management can always elect to delay the closing if the projections do not hold up.

#### Altoona Discussion and Sense of the Commission

The situation at Altoona is very similar to the situation at Erie – the Draft National Plan proposes to maintain outpatient services and close acute care by 2012. It will then be converted to a critical access hospital.

One Commissioner said Altoona has more community resources and is different from Beckley. She would feel better about the quality of community care available in Altoona.

The sense of the Commission is to deal with Altoona the same way as Erie and Beckley. VA should look again at the availability of community care before converting the facility to a critical access hospital.

#### VISN 4 Outpatient Care

The Commission briefly discussed the outpatient care proposals for VISN 4. The bottom line is that none of the VISN’s proposed new CBOCs made the list of the top 48.

One Commissioner said there was great interest in putting a CBOC in Morgantown, West Virginia where it could get an affiliation with the University of West Virginia Medical School. He said it made sense to him to put a CBOC there.

The Chairman said the VISN had also made a case for adding a new CBOC in Western Pennsylvania. He asked whether it was justified on the basis of the data.

The Commission agreed that this would be handled as a crosscutting issue and be based on analysis of additional data.

### Pittsburgh Discussion and Sense of the Commission

The discussion of Pittsburgh proposals began by stating that the Draft National Plan proposes a realignment under which services at the Highland Drive facility would be transferred to the University Drive and Aspinwall campuses and construct new facilities for psychiatry, mental health and related research and services. VA will close Highland Drive and evaluate the potential of the property for enhanced use leasing for an assisted living facility. The briefing Commissioner said the domiciliary facility at Aspinwall is newer and has capacity. There are major parking problems at Highland Drive.

A Commissioner said he concurs with the clinical value of the proposals included in the Draft National Plan. He would recommend approval depending on what the cost-benefit data, yet to be submitted, shows. He asked the staff to look at the full life cycle savings of the plan over the next 10 years.

The Chairman said the sense of the Commission on Pittsburgh would be to recommend the proposal subject to analysis of the additional data. Additionally, the Commission should note that the Plan is dependent on improvements to the University Drive facility that will be needed sooner rather than later.

### VISN 4 Eastern Market Proposals – Discussion and Sense of the Commission

The Commission next took up the proposals for the Eastern Market of VISN 4 – the Philadelphia area. There is a primary care gap that the Plan proposes to meet by establishing five new CBOCs.

A Commissioner said he has no issue with the mental health service proposals for eastern Pennsylvania.

A second Commissioner said that VA was more aggressive about looking at what types of tertiary services could be consolidated in Philadelphia. He said there are political implications associated with doing that, but there is also some potential.

It was noted that there is interest in having a hospital in South Jersey and political support for it. The problem is that it would make Wilmington less viable. VA does not support the idea of a new hospital there.

One Commissioner said the gap for SCI beds in VISN 4 is as big as any and asked why the Plan does not recommend more SCI beds there. The Eastern Paralyzed Veterans Association claims the numbers would support one. Another Commissioner said the data shows there is a need, but the Draft National Plan does not address it.

A Commissioner recommended that the Commission support another 30-bed facility in this VISN. He added that studies have shown that 30 beds is the optimum size for an SCI unit.

A Commissioner asked whether the Commission shouldn't put a contingency on the recommendation based on need. He said if a unit isn't filled, it isn't cost-effective. He would like to have data on the occupancy rate of what is there now.

Another Commissioner said the argument being made is that a lot of Philadelphia-area SCI patients are coming to New York now. A new unit in Philadelphia will relieve the pressure on New York.

One Commissioner suggested if that is the case the recommendation should be to establish a new facility in Philadelphia as VHA phases out East Orange into the Bronx. This would let VA move toward a single SCI Center in the New York area while establishing a new SCI Center in Philadelphia.

Ten percent of all national nursing home patients are in this VISN. The VISN requested five new nursing homes, noting that some conversion is possible, however, by law, VA can not reduce its nursing home beds below a certain point. A Commissioner cautioned the Commission about reducing nursing home beds and spending the money elsewhere before it gets new national projections of nursing home needs.

The Commission agreed to recommend that VA consider establishing a new SCI facility in Philadelphia as the East Orange facility is phased out.

#### Sense of the Commission (more)– VISN 4

The Commission's discussions in this VISN were summarized as being to recommend completing the enhanced use lease at Butler before undertaking an enhanced use lease at Highland Drive.

The Commission also agreed that Wilmington and Philadelphia are both busy and both working well. However, if VA can consolidate services at these facilities it should do so.

### **VISN 9 – Kentucky, Tennessee and Mississippi (part)**

#### Presentation of Data and Issues

The Commissioner who led the presentation of the proposals and issues in this VISN said the hearings took place in Lexington and Nashville. He said one big issue concerns access to CBOCs. For example, it is a three-hour trip from Hazard to Lexington to get primary care.

The Draft National Plan proposes to close the Leestown campus, which is primarily a nursing home that is located five miles from Lexington, Kentucky. The Cooper Drive campus is located in a very crowded part of town, which restricts improvement. Instead, the Plan proposes to add two stories to the Cooper Drive division and close Leestown. One difficulty will be that there is already a parking problem at Cooper Drive.

The Commission is recommending that VA consider a two-fold plan. The Kentucky State psychiatric hospital wants part of the Leestown campus. VA should move quickly on that proposal. But it should continue Leestown as a separate campus as a nursing home. A lot of the land there might be attractive for enhanced use leases – there are many possible uses.

A second Commissioner added that, historically, Leestown was a long-term psychiatric hospital. They got out of that business, but the nursing home still has some psych patients. Asked about

the number of beds, the Commissioner said there are none that they would call long-term psych beds.

The Commissioner said the VISN's plan for long-term psych is incomprehensible. It projects a large need in the northern market. The proposal, which is to consolidate acute and long-term inpatient psychiatric care at Murfreesboro, makes no sense. He said the Draft National Plan is in error when it says there is a documented need in only two of the VISNs four markets – there is a need in all four. There is a severe lack of long-term psychiatric care in the VISN and the need exists *now*.

A Commissioner said the Plan recommends a domiciliary facility at Leestown. He also said the Plan recommends construction of a new facility at Louisville. The visiting Commissioners agree that a new facility is desperately needed there. The current facility is 50 years old. The new facility should be located close to the University of Louisville Medical School, which is a VA affiliate. The Medical School dean testified at the hearing that the market plans made sense.

#### Commission Discussion and Sense of the Commission

A Commissioner asked about primary care at Lexington, noting that the facility is “land locked.” He asked about the possibility of taking things out of that facility and putting them at Leestown or at a CBOC. A second Commissioner said outpatient care in this market is another issue. Another Commissioner said VA must include mental health services in their outpatient facilities in this VISN. He doesn't want VA to pay the State of Kentucky for the care of a veteran in a state facility.

One Commissioner asked about VA-DoD collaboration in this VISN. The answer was there is collaboration with Fort Knox and it is working well.

Also noted is that the Draft National Plan proposes to collocate the Regional Office with the Louisville hospital.

The Chairman indicated the sense of the Commission in this market should be to indicate to VA that it thinks closing the Leestown campus is not a good idea. VA should keep it open and take another look at how services are distributed. Additionally, the Commission would recommend that VA excess vacant space at Leestown to the State of Kentucky immediately.

#### Discussion of VISN 9 Southern Market; Sense of the Commission

In Nashville, the hearings were attended by the deans from two medical schools – Vanderbilt and Meharry. He said the two schools are working together very well, which is very surprising because it rarely happens.

One Commissioner asked about CBOCs in this market. The VISN requested 29 new CBOCs, but none of them were included in the top priority. A Commissioner commented that the VISN didn't apply the needed discipline to combine CBOCs, so they wound up with none. He said this is another example of the “numbers exercise” at work. He pointed out that this was a VISN where VA had contracted with non-VA providers for services in small towns. The result was eight CBOCs that have a total of 2,000 patients. Another Commissioner said the VISN plan for CBOCs was more of a “wish list” than a plan.

The Commission agreed to recommend that VA should reevaluate the need to provide mental health services in the current CBOCs in this VISN and establish the need for new CBOCs based on where the veterans live. The Commission agreed to note that there are documented mental health care gaps in all four markets in this VISN. The current acute mental health care unit in this VISN should not be consolidated or moved.

### Specialty Care Issues in VISN 9

A Commissioner asked about the proposal to add 20 long-term SCI beds at Memphis. The answer given was that Memphis is not filling the beds they have now. Consequently additional data would be needed to support this proposal,

The same Commissioner also said there is a need to look again at the need for blind rehabilitation services in this VISN.

### **VISN 10 – Ohio**

#### Presentation of Data and Issues

The Commissioner who presented the data and issues for VISN 10 said the Commission held hearings in Cleveland and Columbus. The VISN operates five hospitals: Dayton, Cincinnati, Columbus, Cleveland and Chillicothe.

At the hearings, the Dayton Medical School Dean testified. In Columbus, three Members of Congress testified – all very well versed.

At the Cleveland hearing, the main issue that emerged was the proposed closure at Brecksville. This campus realignment was proposed by both the VISN and the Draft National Plan. Capacity will be maintained through new CBOCs. The Commissioner said the Brecksville people made a good presentation. It makes good sense to realign the campus, but it will be an economic problem for the community.

#### Brecksville Discussion

The Chairman asked whether VA should hold off closing Brecksville until the new improvements in Cleveland are underway. The Commissioner said the proposal is to phase in the changeover. Cleveland has plans to house some of the Brecksville domiciliary patients in Wade Park, with 2/3 under the Volunteers of America.

More data is expected on this issue as it is a realignment issue.

The Commissioner said a major problem now is that transportation costs are expensive. The VISN claims it will save enough money in maintenance at Brecksville to pay for new facility construction in four years. He said he would need to see the data before he could accept that estimate. A Commissioner said he agrees that the change would be an improvement clinically, but he would also like to see the financial data.

One Commissioner said the greatest inconvenience would be to the employees, some of whom would have to drive an extra 35 miles each way to and from work.

### Columbus Discussion

The Commissioner said the other priority in VISN 10 is Columbus, where a new outpatient specialty care clinic would be built and demand is growing to the point where the VISN can use a new CBOC. The VA will acquire the land for these facilities from the Defense Supply Service. He said there are Medical School operations in Columbus now at more than one site. A new clinic will help to consolidate these operations.

One Commissioner noted that Columbus is the fastest growing VA area in the country.

The Chairman noted that VA now hauls people around from Columbus to Dayton and Cincinnati to get outpatient treatment. The route is over 100 miles. The practice is inconvenient and expensive. Accordingly he believes the Commission should recommend that VA should give this clinic priority.

### Chillicothe Discussion

One Commissioner asked about the Chillicothe facility. A Commissioner replied that Chillicothe is the regional psych facility for the Columbus area. It is located 60-70 miles away on a two-lane highway. If VA were to build a regional facility new, it would have put it in Columbus. It did not address reality when it located this facility in Chillicothe. The VISN credits Chillicothe beds with serving Columbus, but they don't do that really.

One Commissioner noted that the VISN claims it can contract out new patients. A Commissioner said if the VISN does that it will have a huge impact on Chillicothe and Chillicothe will become even more isolated than it is now. The Commissioner said there are also some dom beds at Chillicothe that are used for residential rehab for Columbus patients.

The VISN is not projecting any decline in Chillicothe except for outpatient care associated with the new clinic. A Commissioner noted that the enrollment projections for Cleveland and Columbus are constant.

One Commissioner suggested the VA should check out whether it could get more land from DoD around the proposed new clinic for a long-term psychiatric facility that would place veterans closer to their families.

### Sense of the Commission

The Commission's working recommendation regarding Columbus is that it strongly supports the construction of an expanded outpatient clinic. It also supports contracting out inpatient work. The Commission also notes that this will have an impact on Chillicothe over time and strongly suggests that VA look at what the impact would be and how to deal with it.

### Cincinnati Discussion

In Cincinnati, the Draft National Plan proposes to establish new CBOCs.

One Commissioner said there is no parking at all at the hospital. The proposal would off load work from the hospital to a new CBOC on the outskirts of the city. Another noted there is land available for the CBOC at an old military post. Another Commissioner said he believes Cincinnati is a very strong hospital. He agrees that parking there is major problem.

The Commission agreed with the recommendation to establish a new CBOC at Cincinnati.

**Thursday, October 16, 2003**

**Continuation of VISN-Level Review of  
Draft National CARES Plan**

Chairman Alvarez opened the public session of the Commission meeting asking for observations on VISN 8.

**VISN 8 – Florida, Puerto Rico, Georgia (Part)**

Presentation of Data and Issues

The Commissioner leading the briefing stated that four VISNs – VISN 6, 7, 8 and 13 – are scheduled to get 36 of the high priority 48 new CBOCs. These are the VISNs where enrollment is high now and growing rapidly.

VISN 8 is the largest VISN based on workload. It covers most of Florida – everything except the Panhandle – and the southern tip of Georgia and Puerto Rico. The VISN has seven hospitals, thirty-four CBOCs, eight nursing homes and two domiciliaries. It is experiencing growth in all markets and sub-markets. Between 2002 and 2022, the Network's market share is expected to increase from 27 percent to 36 percent. Workload has grown from 267,000 to 450,000 since 1998. The VISN has 15,000 full-time equivalent (FTE) employees and an annual budget of \$1.8 billion.

The exception to these numbers is Puerto Rico, where there is declining workload across-the-board. Enrollment in Puerto Rico has been reduced by half over the past 20 years. There is a projected spike in demand for psychiatric care, then a drop off. The Commissioner reported that he has no problem with how the VISN is planning to handle this decline, which is through downsizing, new hospital construction and joint ventures in outpatient care with Fort Buchanan.

The big issue in Puerto Rico is meeting safety requirements. There is a seismic issue at the facility and the VISN should move ahead with fixing it. There is also a question of how big the new bed tower should be – three stories or six stories. The VISN will need more money for these projects, but it is a priority issue and he recommends moving ahead with the improvements.

Discussion of Puerto Rico Proposals

When one Commissioner noted that the decline in enrollment is dramatic and asked the reason for it, the lead Commissioner said the cost of enrolling seems to be the primary driver. He

observed that the drop in enrollment indicates the Commission should emphasize the need to properly size the planned improvements.

A second Commissioner asked about the VA market share in Puerto Rico. When the lead Commissioner replied that the VA has a high market share, he was asked why it was projected to drop. Another Commissioner suggested that the proportion of Puerto Ricans serving in the military has dropped dramatically under the all-volunteer military.

The Commissioners had serious questions about the validity of the accounting data and had difficulty breaking down the data for Puerto Rico, advising that the situation is not helped by the steady flow of people back and forth between New York and Puerto Rico. Another Commissioner said the Commission's recommendation should also emphasize the need to make an effort to improve the data.

With regard to outpatient care, the Draft National Plan includes a big increase for specialty care and a modest increase for other types of care. The Plan provides for care partially through the Medical Center and partially through the two outpatient clinics. The mini-market plan included two more outpatient clinics, but these were not incorporated in the Draft National Plan.

It was noted that the Ponce clinic is very large and that the levels of priority category eight veterans in Puerto Rico is very low – only three percent. The Director would like to open a new hospital at Fort Buchanan, but that is not likely to happen. There are also joint projects under consideration for Roosevelt Roads and Fort Buchanan, but these probably won't happen either.

#### Sense of the Commission

For Puerto Rico, to aid in resolving the seismic issues, the Commission agreed to recommend that VA build a new bed tower and ensure that it is properly sized.

#### Discussion of Other Markets in VISN 8

For *inpatient care* for the rest of the VISN, the projection is for a big demand for inpatient psychiatric care beds. Additionally, the VISN is projecting increasing market share across-the-board.

One Commissioner asked how current migration patterns are likely to affect the projections in this VISN. He noted that many people who moved to Florida for retirement are now beginning to move part of the way back to the North. The response was that even figuring in the migration patterns, the VISN is still showing growth.

Another Commissioner observed that there are a lot of priority category eight veterans in this geographic area. Consequently, what this VISN will need is very dependent on VA enrollment policy.

For the *northern market in VISN 8*, the plan is to build a new bed tower at Gainesville that will be a 135,000 square-foot facility with 138 new beds. A Commissioner said he does not understand the proposed mix and isn't sure how a new bed tower is justified. The Plan calls for moving inpatient surgery from Lake City to Gainesville, leaving only nursing home and outpatient services at Lake City.

One Commissioner said he believes there are capacity problems at Gainesville. The beds there are always occupied. A second Commissioner said the reason Gainesville is always crowded is that it is a referral hospital. There are also big seasonal fluctuations – the workload there is enormous in January, February and March.

It was asked whether the Commission would be inconsistent if it didn't endorse more inpatient capacity in this market. One Commissioner suggested that the Commission should recognize the need but indicate that the Milliman data might not be the best data to use because of the seasonal fluctuations in workload.

One Commissioner said the data shows a 50 percent deficiency in the market for inpatient medicine. The Plan is also saying there will be an increase in capacity due to a joint venture. There are two joint ventures planned: one in Gainesville with the University of Florida and one with the Jacksonville Naval Air Station. The VISN will contract out patients with the University of Florida until it can get the bed tower built. Another Commissioner said he believes they need to be more specific about what they are going to do in this proposal.

It was suggested the Commission recommend that given the declining surgery needs, the Commission would like to have data on why the VISN needs a new bed tower and details concerning the proposed joint ventures.

#### Lake City Discussion

The other issue in the north market of VISN 8 is the proposed realignment of Lake City. The original proposal called for turning the hospital at Lake City into an eight-hour operation. The proposal upset the local people who are trying to keep the facility open. He said the Draft National Plan would transfer only inpatient surgery to Gainesville. Nothing else would be moved out of Lake City before 2012. VHA intends to revisit the Lake City issue after the new Gainesville bed tower is built. The recommendation is that the Commission concur.

#### Discussion of Other Markets

The Plan calls for expanding capacity in the *Atlantic Market* by adding 15 beds at West Palm Beach and 33 beds at Miami. The VISN will achieve this internally without new construction. The plan also calls for increasing inpatient psychiatry at both West Palm Beach and Miami.

In the *Gulf Market*, the demand for inpatient beds is decreasing. The VISN has agreed to a downsizing through internal realignment. The psychiatric care capacity at Bay Pines will be increased.

Bay Pines has some tertiary services but not all. The facility doesn't need to have all tertiary services because it is close to Tampa and the University of South Florida.

For the *Central Market* in VISN 8, there is a slight increase projected in demand for inpatient care, a declining demand for surgery and a big drop in demand for psychiatric care. The Draft National Plan recommends constructing a new acute care inpatient hospital in Orlando. This recommendation is based on access considerations – only 45 percent of veterans in this market have access that meets the criteria. Staff has asked for additional information regarding the size

of the proposed facility. It was recommended to concur with the Plan in principle pending the review of additional data.

It was noted that even though the Florida Panhandle is not part of VISN 8, there is a need for more inpatient services there. The recommendation is that both VISN 8 and VISN 16 should evaluate that need and provide a joint plan.

A gap at Jacksonville was also noted.

One Commissioner suggested consideration should be given to potential collaborations at Pensacola Naval Hospital.

A second Commissioner suggested that the North Florida Market might be a better place to put a hospital than the Central Market given the size of the gap there. It was reported that the VISN Director thinks the Panhandle has a greater need than Orlando. The Panhandle would be his first priority location for a new hospital.

It was suggested that the Commission report recommend that VHA begin looking at how it will meet the projected need in the two markets – the Panhandle and the North Market.

One Commissioner said there are excellent medical facilities in Jacksonville – civilian as well as military. He suggested there might be some potential for a joint venture there. Another Commissioner also suggested that VA should not give up on the Naval Hospital at Jacksonville yet. A third Commissioner agreed with the Chairman’s recommendation, noting that the access data does not support putting a hospital in Orlando (with 45 percent access) over either Pensacola (with four percent) or Jacksonville (with 16 percent access).

#### Discussion of VISN 8 Outpatient Care Proposals

The Draft National Plan would add four new CBOCs in this VISN, primarily in the North Market. Outpatient demand is growing in all markets in this VISN.

One Commissioner said he has “grave concerns” about outpatient mental health in this VISN. Seven of the eight CBOCs in the Gulf Market have no mental health capability. None of the six CBOCs in the Atlantic Market provide mental health care and only four of the seven CBOCs in the North Market do. His concern is that the pattern is inconsistent. VHA is choosing to ignore some very large mental health gaps. The Commissioner also said the wording of the Draft National Plan is wrong and should be corrected. His recommendation is that VHA should be required to address mental health needs in all existing and new CBOCs.

#### Other VISN 8 Proposals

It is still not clear what the Draft National Plan proposes to do about *vacant space* in this VISN. The Commission has asked for better data.

It was noted that the Plan for Tampa includes a new inpatient bed tower plus more spinal cord injury (SCI) beds. The proposal is to add the SCI beds first, then add the new bed tower on top of them. Also noted is that the electrical system at the Tampa facility is in need of repair or replacement.

A Commissioner noted that the proposal for 30 new SCI beds is driving the decision about the rest of the tower. He said the Commission needs more data before it can make a decision about Tampa.

The Chairman said the sense of the Commission in Tampa is that the Commission is waiting for more data.

## **VISN 11 – Indiana, Michigan, Illinois (Part)**

### Presentation of Data and Issues

The Commissioner who led the discussion of the Draft National Plan for VISN 11, which included hearings in Fort Wayne, Indiana and Detroit, Michigan, said that the hearing in Fort Wayne was a raucous affair. The veterans who attended had been told it was a town meeting. The hearing reflected the state of planning in this VISN. The Fort Wayne facility is a small facility with inpatient care. The Draft National Plan envisions closing acute inpatient services at Fort Wayne, transferring those services to Indianapolis and converting Fort Wayne to an outpatient facility. Fort Wayne is more than two hours from Indianapolis and the area is suffering economically, but the facility has only eight acute beds and that number is projected to decline.

Before the VISN could shut down services at Fort Wayne, it would need to go back and develop a plan, which it does not have now. In addition, the Commission needs more data, especially in regard to savings.

The VISN has a very large psychiatric facility in Marion. There are 15 buildings on the site, including a new building with empty wings. The Draft National Plan proposes to close the acute beds at Marion and transfer the services to Indianapolis. Again, the VISN has not developed a plan for this change.

One Commissioner noted that the information provided to the Commission says that this change has already been accomplished outside of CARES, so no action is needed.

In Danville, Illinois, the Draft National Plan proposes to get rid of excess space in old buildings, but again presents no specific details.

### Outpatient Proposals

The VISN had asked for lots of new CBOCs in this market, but none of them made it to the top tier priority —the list of 48. The community is upset about this because it thought it would get CBOCs to replace the Fort Wayne facility.

The Chairman said the Commission would recommend that the VISN submit a detailed plan. Data from this market on CBOCs is available.

One Commissioner observed that VISN 11 is a somewhat unique market. It has the lowest market penetration of any market despite growth in demand.

Another Commissioner discussed the Michigan hearings and proposals. He noted that enrollment in this VISN is projected to go up. The VISN is projecting an 84-bed deficit for inpatient medicine. The Draft National Plan proposes to close the inpatient unit at *Saginaw*, Michigan, leaving outpatient care and the nursing home. He said the closure seems valid to him as long as VHA has the option to contract for care in the community.

In both *Detroit* and *Ann Arbor*, an increase in inpatient demand is projected. In Detroit, VHA has overbuilt. If it activates the space it already has, that space could be used to handle the projected increase. He also doesn't believe VA needs to construct new beds at Ann Arbor as proposed in the Draft National Plan.

In regard to *outpatient care* in the Michigan Market, the Commissioner said there are significant gaps. The Plan proposes to meet the gaps by increasing activity at the current locations and by establishing three new small CBOCs.

The sense of Commission was to review the new CBOC proposals on the same basis as all other CBOC proposals.

## **VISN 15 – Kansas, Missouri, Southern Illinois**

### Presentation of Data and Issues

The Commissioner who led the discussion on VISN 15 indicated that no enrollment growth is projected in this VISN. The Draft National Plan calls for expanding existing facilities, converting facilities and contracting out to handle a projected expansion of workload in primary and acute care.

He reported that Kansas City is pretty well built out, that he is not sure how it plans to deal with the increasing workload, but there is time to review options.

Regarding *outpatient care*, he said many facilities have infrastructure needs – safety improvements, for example. He said the Commission did not get any specifics on these needs.

The VISN is moving inpatient psychiatry from Wichita to Topeka – the move is already underway. The VISN is also moving some patients from Leavenworth.

### Leavenworth Discussion

The proposal for an enhanced use lease project at Leavenworth is a significant problem. The buildings on the property are not likely to be used for anything else. They are wooden buildings that are on the historic register.

One Commissioner said the figures show a saving of \$133 million over 20 years at Leavenworth. Another said he would have difficulty believing those figures. A staff member said the data is being checked. The Commissioner raising the issue said the report should point out that taxpayers should not have to spend \$133 million from the VA medical care appropriation over the next 20 years to maintain some historic old buildings at Leavenworth that are of no use.

### Poplar Bluff Discussion

In the *small facilities* category, the Draft National Plan proposes to continue operations at Poplar Bluff as a critical access hospital (CAH). Poplar Bluff is authorized 40 beds but is operating only 18. The occupancy rate of those beds is 80 percent, with 95 percent of the long-term care beds occupied. Poplar Bluff is an old facility that treats about 55 patients. It appears to be a matter of time before the facility will go away. In the meantime, there is a problem with contracting out to the community because the local hospital is experiencing difficulty. The briefing Commissioner believes that the CAH designation is appropriate for Poplar Bluff but the Commission should look at the proposal the same as the others.

### Special Disabilities

The VISN 15 Director is proposing to move acute spinal cord injury beds downtown. This move came as a surprise to stakeholders. In response to a question about stakeholder reactions, the Paralyzed Veterans Association indicated it is adamantly opposed to moving the SCI beds.

### Other VISN 15 Proposals

There is a substantial and growing collaboration between VA and DoD at Fort Leavenworth with great potential for this collaboration to expand in the future.

The VISN also requested three new CBOCs in the East Market that seem justified but were not included on the tier one list.

## **VISN 16 – Oklahoma, Mississippi, Louisiana, Arkansas**

### Presentation of Data and Issues

VISN 16 has four markets and seven hospitals.

### Gulfport-Biloxi Discussion and Sense of the Commission

The biggest issue is the campus realignment at Gulfport-Biloxi; the proposal is to vacate Gulfport by 2009. The target market is the Florida Panhandle. The VISN is trying to collaborate with Florida to improve service to this market. The Plan also proposes to increase collaboration on inpatient surgery with Keesler Air Force Base.

One Commissioner said the next base realignment and closing (BRAC) may affect Keesler. The base commander at Keesler is concerned about BRAC and thinks that if he can hook up with VA, Keesler might not be on the BRAC list. A Commissioner commented that TRICARE is actually drawing patients away from the Keesler facility. Another Commissioner said he did not get the impression that the collaboration discussions between VA and Keesler were headed in a 'go' direction.

The VISN had said Keesler had the capacity to absorb the excess workload, but the base commander said Keesler had no capacity. If the VA wants to share the Keesler facility, the Commander said it would have to build there. One Commissioner noted that his understanding was that Keesler has the beds but not the staff to accommodate the additional workload. Another Commissioner agreed, observing that Keesler has over 200 beds – plenty of space but no staff.

A Commissioner commented that the Gulfport-Biloxi realignment proposal is very well documented.

The Chairman said the Commission would defer its recommendation on the proposed realignment pending the receipt of additional data.

#### Discussion of Muskogee Proposal

The briefing Commissioner introduced a discussion of the Muskogee small facility proposal. The Draft National Plan calls for Muskogee to keep its inpatient program but study its other programs. The Commissioner said the biggest potential population at Muskogee comes from Oklahoma City and the VISN would like them to go there for care instead of to Tulsa.

One Commissioner said he agrees with the idea, but indicated it will be a challenge. A second Commissioner said the cost of the proposal, \$543 million, is too high. Another Commissioner said the facility at Muskogee is a relatively new building, two floors of which have never had a patient. He said the VISN has not tried to attract new patients.

Asked if the VA could seek collaboration with the Indian Health Service in Muskogee under which the Service would buy services from VA, the reply was that it would be a good idea but that there would likely be bureaucratic problems.

One Commissioner suggested the best solution might be to expand Oklahoma City and phase out Muskogee. It was suggested that the Commission will want to mention that Muskogee should not stay open in the long term. It was suggested that the recommendation be worded differently: i.e., “there is such a large veteran population in Tulsa that VA should consider increasing capacity in that market area.”

In the area of *outpatient care*, the VISN is scheduled to receive 11 of the 48 high priority new CBOCs. Only two of the CBOCs are actually new; the VISN would be expanding others. The VISN claims the new CBOCs would provide access to 31,000 new enrollees but this does not meet the standard of 7,000-enrollee per CBOC.

With regard to *special disabilities*, the Draft National Plan proposes to build a new 20-bed Blind Rehabilitation unit at Biloxi. The briefing Commissioner observed that this unit might be more appropriately located in Gulfport, saying he is not sure about space availability in Biloxi. Another Commissioner indicated that there is room at Biloxi. The Commission agreed to recommend the establishment of a new Blind Rehabilitation Unit at Biloxi provide that space is available.

One Commissioner suggested that the Commission’s report should also note that there is a documented need for outpatient mental health services in several markets in this VISN. There is only four percent access in the Southern Market now.

The Commission also agreed to strongly recommend the need for improved inter-VISN cooperation between VISN 16 and VISN 8. This would address the need for better access to care in the Florida Panhandle.

## Shreveport Discussion

It was reported that about 100 people attended the Shreveport, Louisiana, hearing and the VISN Director did a good job organizing it.

The issue in this market is access to primary care. Driving time is a big issue – there are major traffic problems. The VISN would have to add a lot of CBOCs to resolve the issue, and ten are approved in the Plan. However, there is no agreement between VA Central Office and the VISN Director regarding the specific locations of the new CBOCs.

The plan for new CBOCs in this VISN came in before the 7,000- enrollee criterion was established. The computer model would show where the CBOCs should be located to best reduce access gaps.

Regarding the Central Lower Market proposal (Alexandria/Shreveport), a Commissioner said he is seeking a more specific written statement from VHA about how it plans to resolve specialty care gaps – more than just “as many as we can.” He said there is a private sector proposal coming to develop a multi-specialty facility. It would be developed on VA property and VA could use it. He noted that services are maxed out now and work needs to be shipped out to other facilities. There are problems with access to both primary and specialty care, and he is not sure how the problem will get solved. He said the Alexandria surgical facilities are not up to speed. He suggested emphasizing extended care at Alexandria and sending surgical patients to Shreveport. He recommended the Commission’s report should indicate that there should be more focus on inpatient care. The VISN should examine projected growth. The Commission should also support the proposed new CBOCs. In addition, the Commission should support the Shreveport/Alexandria proposal if VA supplies more supporting data.

One Commissioner noted that VA has had some experience with enhanced use leasing in this VISN and might be able to pull off the proposed deal with the private sector.

A second Commissioner said that there is no SCI facility between Memphis and Houston. His view is that Shreveport would be a better location for an SCI facility than either New Orleans or Little Rock (where the Plan now proposes to put one). Another Commissioner noted that there is a strong medical school relationship available at Shreveport.

Another Commissioner recommended that the Commission report discuss *state veterans homes*. He said they are another resource available to veterans. They should also be a factor in siting new facilities. He would like the report to integrate information of state homes with other factors.

## **VISN 17 – Texas (Part)**

### Presentation of Data and Issues

In VISN 17, the Commission held hearings in San Antonio and Waco. Attendance at the San Antonio hearing was low – only nine people other than staff and VISN people. By contrast, the Waco hearing drew 2,000 people.

The South Market – the valley/coastal area – is growing and underserved now. There is a real need for primary care access. The Draft National Plan addresses the need by proposing to contract for care unless there are special needs; those patients would be sent to San Antonio.

In the area of *outpatient primary care*, the Draft National Plan proposes moving the VA facility at Brownsville, Texas to Arlington. The new facility would be a joint facility with the University of Texas at Arlington Medical School. The Medical School is constructing a new building there and would share space with VA. The lead Commissioner briefing this VISN believes the Commission should recommend this proposal.

### Kerrville Discussion

The Draft National Plan proposed a realignment that would transfer acute inpatient services from Kerrville to San Antonio. The issue is whether or not to do this. The VA claims there is a space problem; the Commissioner thought that space could be made available. The VISN also claims that transportation costs are expensive and subject to peculiar city ordinances.

A Commissioner said the Kerrville facility has two buildings – an old part and a new part. He said the new part and the assisted care facility are working well. However, he has questions about the old part. It has 25 beds, 10 of which are operating. He said some people have a great passion to keep the facility there, but they won't use it. He said he believes strongly that Kerrville does not meet the criteria for conversion to a critical access hospital (CAH). The space is ill suited even for primary care. He said that of all the places he has seen, this one was the least willing to consider any suggestions about alternatives. All ideas were met with a stone wall.

The Chairman noted that the Commission would recommend that San Antonio should absorb the Kerrville acute inpatient services now. He said the recommendation is driven by the improvement in the quality of care that would result. Kerrville should continue providing other services.

Regarding *outpatient care*, the Plan proposes joint CBOCs with DoD. It was noted that the collaboration with DoD in this VISN is working well. The new CBOCs would help to unload capacity from San Antonio to make room for expanding inpatient care.

A Commissioner said he would like the report to emphasize the importance of providing teaching clinic capabilities at the new CBOCs.

Another Commissioner spoke to the *Central Market* proposals. He said the Market has two sub-markets, one around Austin and one in the Waco-Temple area.

In the Austin area, over 50 percent of the veterans use VA services. The CBOC is unable to handle this workload. The VISN proposes to double the size of the CBOC and relocate it. The Commissioner said the University of Texas also wants to build a hospital in this market and would like to enter into an arrangement with the VA. He said this seems like a good deal and believes the VA should accept it.

In the Waco-Temple area, the projections show declining demand. Marlin is basically closed already. There is only a domiciliary and an outpatient clinic there.

Waco was built in 1930 and there has been a lot of investment in the facility there over the years. It is primarily an inpatient facility, with 109 inpatient psychiatry beds. There are also other services on the Waco campus, including outpatient services and nursing home beds. The Draft National Plan proposes to transfer the 109 inpatient psych beds from Waco to Temple, a distance of 35 miles. The rest of the operation would also be moved off campus and Waco would be closed.

The Commissioner said that the 109 psych beds represent six and one-half percent of the total workload. The plan would move the affected employees with the patients. It now costs \$12-\$15 million annually to keep the facility operating and it is operating at a loss. He said the proposal in the Draft National Plan seems sound, but the local community has become very involved in trying to keep the facility open. The local task force put together a briefing book. The task force does not see that the proposed move will not substantially affect the workload. Both clinically and business-wise, the proposal makes sense.

One Commissioner said Waco is a case where CARES could have handled the situation better. None of the outpatient programs there will change at all. Almost everything the Plan proposes to do there would be an enhancement. He said if VA is forced to keep the facility open, it would have to change the services there to meet costs.

In response to a question as to whether the plan was to close the Blind Rehab unit and contract out the services, it was noted that Blind Rehab services would be moved to Temple not closed and contracted out. He said most of those patients come from the southern area. Another Commissioner noted that the blind stakeholder groups have no problem with relocating the facility; they are only concerned with where it will be.

One Commissioner said the strength of the proposal lies in moving the acute psych beds to Austin, where the people live. VA needs to be careful there isn't a mission change in the nursing home beds at Temple. He said the VISN is doing the right thing. He also said VA should do in Chillicothe what it is doing in Waco. The situations in the two localities are comparable.

There was discussion that the community may want to convert some of the buildings in Waco for use as a college, however, the buildings are very old and have common electrical systems, steam heating and similar features that would make conversion impractical. Also, the Director has offered to put a new outpatient facility at the same site that would provide the same outpatient services people are getting in Waco now.

Another Commissioner voiced the view that the biggest factor would be the cost-benefit analysis. He noted the facility is losing \$12 million a year now.

The Chairman said the Commission would be inclined to support the proposal as it now stands but it will not make a decision until it has more data and can do more analysis. The decision should be consistent with the decisions about Highland Drive, Brecksville and Gulfport.

As a final matter in VISN 17, it was noted that the Dallas Market is looking at three areas as potential locations for CBOCs – Arlington, Plano and Ft. Worth.

## VISN 18 – Arizona, New Mexico, West Texas

### Presentation of Data and Issues

A Commissioner opened the discussion of VISN 18 by noting that veterans in Arizona have good access to primary care, hospital care and tertiary care. In the area of *outpatient care*, the VISN is proposing to expand primary care services at CBOCs. One reason he agrees with that proposal is that the hospitals in Tucson and Phoenix are pretty full. The VISN had proposed seven new CBOCs to shift the workload off the hospitals. The CBOCs did not make the priority list.

The Draft National Plan's proposal to expand acute inpatient beds at three facilities received favorable comments. Another proposal in the Plan is renovation of some nursing homes to expand extended care services.

There is a *small facility* at Prescott that is proposed for retention. Prescott is now a small facility with a dom and a nursing home. There is a lot of development taking place between Phoenix and Prescott. VHA is expecting demand to expand in the northern part of Arizona. The Plan calls for keeping the acute beds at Prescott to relieve Phoenix and promote physician recruitment for outpatient and specialty care. The Plan would also move 19 beds from Phoenix to Prescott. It was noted that if VA does that, Prescott would no longer be a small facility.

One Commissioner said that some concern had been expressed about access for Native Americans in the northern part of the state and asked if the Plan included anything specific for them. He was advised that there is a CBOC in the north and that VA has a mobile unit that is driven to the reservations. He was also advised that an American Indian representative had talked to the Commissioners about the need for more services in that area.

One Commissioner said the VA does several different things to reach out to Native Americans, including providing sweat lodges and native healers, but it is a complex matter. There are 20 tribes in the area, all with different customs. Another Commissioner pointed out that the land areas involved are huge. He said VA has been making every effort to reach Native American veterans.

It was suggested the Commission should support the use of nurse practitioners for Indian health care. They would need supervision, but they operate on their own with a protocol. The issue was raised as to whether there might be licensing requirements that would prevent using nurse practitioners. It was noted that VA policy is to abide by state laws in regard to licensing for types of practitioners. One Commissioner said that this is not likely to be an issue and that patient satisfaction with nurse practitioners is high.

With regard to the West Texas/New Mexico market, it was noted that 72 percent of veterans in this market have access to primary care, but that access to hospital care and tertiary care is less than provided for in the VA guidelines. The VISN is proposing to increase collaboration with the military base at Beaumont to increase access. He said the Commissioners who visited there did not get a strong positive feeling from the DoD people about the chances for success. They question the ability to add VA beds at Beaumont.

The Plan calls for expanding CBOCs to increase primary care coverage and the Commissioners agree with that Plan.

For mental health, the Plan is to increase outpatient mental health care at CBOCs.

The Plan also includes an enhanced use lease project at Albuquerque that would allow collocation of the Medical Center and the Regional Office.

The Draft National Plan also calls for studying the feasibility of developing a critical access hospital in the Odessa-Midland, Texas, area to replace Big Spring. The issue is how best to provide health care to this rural area. The Commissioners agreed with the proposal to conduct a study. In reply to a question posed by a Commissioner, it was noted that the VA would get specific data from such a study.

A second Commissioner said there are very few civilian hospital beds in the Midland-Odessa area. He asked whether VA would be able to contract out care if that facility were shut down. It was suggested that the Commission wait for the data before making a final decision. Another Commissioner said it sounds more like a quality of care issue to him.

One Commissioner said there was confusion expressed about who would do the study. The Network indicated the Central Office is going to do the study; in any event, the Commission still has no data.

Other Commissioners offered differing views about this proposal. One noted that the five criteria for a CAH had not been addressed. A second said he had been optimistic that the Network would be able to solve the recruitment retention problem in this locality, but he didn't get any data to support that view. Also noted was that there has been extensive community involvement on the issue, including from the mayor.

One Commissioner said he is really bothered by how many of the solutions in this market relied on the concept of joint use of the Beaumont hospital. Another Commissioner agreed, saying he would like to have a commitment from senior DoD management before recommending approval.

## **VISN 20 – Montana (Part), Idaho, Oregon, Washington and Alaska**

### **Presentation of Data and Issues**

The Commissioner leading this discussion noted that this VISN is the largest in terms of geographic landmass. However, it has a small veteran population with only 300,000 enrollees (compared to 500,000 in Florida alone), resulting in a few people spread out over a very wide area. There are some urban areas, but not a lot. Additionally, unemployment in Washington and Oregon is the highest in the country.

The VISN has five markets. The Commission held two hearings in the VISN: in Portland, Oregon and Walla Walla, Washington. Enrollment growth is projected at 18 percent. Most of the big growth (double digits) is projected for Seattle and Portland. Growth elsewhere is projected to be steady.

In the *Alaska Market*, the Plan recognizes the need for increases in *outpatient capacity*. The VISN proposed two new CBOCs but they did not make the high priority list. The Commission is recommending that VA should re-evaluate the CBOC proposals based on more information.

One Commissioner said VA should move expeditiously on meeting its outpatient facility needs in Alaska or run the risk of getting stuck with a five-year lease on a facility that is already inadequate.

It was also observed that VA has an excellent collaborative relationship in Alaska with Elmendorff Air Force Base.

In *Washington State*, the VISN requested two new CBOCs. A Commissioner said the VISN should have at least one CBOC north of Seattle – perhaps in Bellingham. He also said there is good VA-DoD collaboration in this market at Madigan Army Base.

All facilities in this market have seismic issues that require attention.

The Plan also proposes a new research building in Seattle where there is a very strong research program. The issue is that VA hasn't yet come to grips with the money requirements associated with the proposal.

One Commissioner said the Seattle facility was built in the late 1940s and it is becoming increasingly difficult to recruit and retain staff there.

In Boise, Idaho, the Plan identifies a need to add to the existing facility to provide capabilities such as diagnostics. However, the market there is not growing.

The area next addressed was the Eastern Washington market. It is a large area with two hospitals – one in Spokane and one in Walla Walla.

#### Discussion of Walla Walla

The Draft National Plan talks about closing Walla Walla and evaluating the potential there for enhanced use leasing. The building at Walla Walla is interesting – it looks like a fort. The campus is 85 acres, a huge plant overall with lots of buildings. The nursing home building there is not up to standards. The budget is \$35 million, but the Director didn't know how much of that was for maintaining the buildings and grounds. The hospital has four or five medical patients, 25 psych patients and 40 nursing home patients. The buildings there are historic and the community cannot afford to take them over. Walla Walla gives VA an opportunity to close an outdated facility and build a fine new outpatient facility. It can contract for the nursing home care. The problem is the psychiatric care beds. There wasn't information about what VA could do with those patients if the facility were to close.

When one Commissioner asked if the facility has a residential rehab program, the response was that it does a little of everything there. It serves a large Native American population. It was suggested that what is needed is someone who is dedicated and creative and who can work out the problems there with local hospitals and other resources. It was suggested that the Commission not recommend closing the facility until more is known as to what would be done with the psych beds.

A Commissioner said that this VISN set up a free-standing residential rehab unit near the Indian reservation, which is unusual for VA to do, although VA also is doing it in VISN 18. Commissioners were told that 50 percent of the adult males in that area are veterans. In addition, American Indians have the highest rate of military service nationwide.

The Commissioner said the Commission recommendation should be to agree with closing the facility after VA figures out what to do with the psychiatry bed patients. He said the plans for taking care of the other workload seem fine.

A Commissioner said the data he has indicates that four of the 19 acute beds in Spokane are psych beds. Staff indicated the availability of psych beds in Spokane would be checked.

Another Commissioner said Spokane has an outstanding mobile clinic that delivers primary care in the area. It should be a model for other areas.

The Commission was informed that the VISN wanted to put a second CBOC in northern Idaho but that the proposal is not included in the Draft National Plan. The Plan does include a proposal for a new CBOC in Yakima.

#### Discussion of Portland

The Draft National Plan for Portland, Oregon includes an enhanced use lease proposal for an assisted living facility but it is understood that after Dr. Roswell visited Portland, he decided to back off this proposal.

A Commissioner informed that there is no room on the Portland campus for an assisted living facility. Another Commissioner said he believes the VA ought to consider enhancing services at that campus.

In the *outpatient services* area, the Commissioner said VA has approved two or three CBOCs for Portland outside the CARES process. The purpose of these CBOCs is to get things off the mountaintop campus. It is very crowded there and parking is a big problem.

A Commissioner noted that Portland has one of the worst driving conditions in the country.

The Commission's consensus recommendation is that VA should not pursue enhanced use leasing at the Portland facility. Instead, it should examine ways to use the facility to provide services that would lighten the load on the downtown hospital.

#### Other Issues

The Draft National Plan also talks about new construction at the Roseburg, Oregon, facility, which is an inpatient facility. The Commission did not get any hard information about the proposal.

There also are seismic issues throughout the whole VISN, which is true all up and down the Pacific Coast. VHA needs to prioritize its seismic work. The Commission agreed that it should not be debating seismic projects.

### White City Discussion

The Draft National Plan proposes to close White City and transfer its domiciliary program elsewhere. The campus will be considered for an enhanced use lease project that would provide an assisted living facility. The Commissioners who were there were very impressed with the domiciliary program being operated for homeless veterans.

Another Commissioner spoke of White City, which is in the middle of Oregon. It provides a broad range of services, mostly for the mentally ill. The staff there has been upgraded in recent years. The facility draws patients from a wide geographic area, including Southern California. It gets a lot of referrals for residential rehab, which it treats then hands back. He said the facility has excellent protocols.

The Commissioner said the facility might not be what you would build from scratch, but it is there. The VISN does not want to close it; the Draft National Plan proposes making a study. He said his view is that it would not make any sense to close this facility. It should be kept open. For domiciliary care, VA can get to where they need to be with the addition of a few beds to what is at White City now.

One Commissioner noted that the Draft National Plan says that VA will relocate patients from White City to other facilities in the Network. The problem with this statement is that there are no other facilities in the Network to accept dom patients.

When asked how VA would defend a decision to keep the facility open, the Commissioner replied it could be defended on a clinical basis. Another Commissioner explained that the facility deals with the hard cases – unemployed veterans who are homeless and suffer from substance abuse. VA is learning how to treat such cases here. The staff is actually tackling the problem and trying to get these veterans back to work. The program is a good thing for many people.

### **VISN 19 – Colorado, Utah, Wyoming, Montana (Part) and Nevada (Part)**

#### Presentation of Data and Issues

The Commissioner who led the discussion of VISN 19 noted that the VISN had a long-term psychiatry facility at Fort Lyons, Colorado, which VA closed before the CARES process started. The VISN claimed that it successfully out-placed the patients from this facility, but it has not done this. A second Commissioner added that Commissioners heard complaints during the site visit. He said caring for these patients should be the mission of the Sheridan facility but Sheridan has walked away from it.

#### Denver Discussion

The number one priority in the VISN is building a new joint facility at the former Fitzsimmons Army Hospital site with DoD and the University of Colorado. The total project is estimated to cost \$2 billion and the campus is superb. The University of Colorado already supports the development. The new facility will give VA 140 inpatient beds and 31 mental health beds. VA would like to have a research facility there and the VISN is also proposing to build a VA nursing home on the site next to the state veterans home.

The Commission should strongly recommend supporting the DoD-VA-University facility.

#### Other VISN 19 Proposals

The VISN's other priorities are to retain acute care in Cheyenne (number two), the East-West Valley CBOC (number three) and establishing a new CBOC in Elko, Nevada (number 4). The Elko CBOC would be shared with Nevada, but it did not make the priority list. The VISN would like the CBOC to be in the new Federal Center at Denver. The fallback, which is not a good idea, is to add to the old facility.

The Commissioner said Denver and Salt Lake City have the greatest demand in the VISN. Both are full now. These facilities must have CBOCs to expand care to meet the demand. Veterans have nowhere else to go.

The Chairman said the Commission would hold off on discussing the Cheyenne, Wyoming, proposal until after the hearing next week.

It was stated that VA meets the access standards for *outpatient acute primary care for only 54 percent of veterans*.

It was recommended that VA dispose of the current facility in Denver if the VISN moves from there, not attempt to develop an enhanced use lease.

The VISN would like to keep its facility at Grand Junction, which is doing a good job. A Commissioner asked if Grand Junction is being treated as a small facility. The staff answered in the affirmative. The Commission will deal with Grand Junction as a small facility.

A number of VA-DoD collaborations are described in the Draft National Plan. However, there is no collaboration going on now between VA and DoD at Hill Air Force Base, which is a small facility near Ogden, Utah.

#### Billings

A Commissioner reported that the highlight of the Billings, Montana, visit was going to the clinic. There is really good work going on there, but it has outgrown its space and really needs to expand. The Billings clinic has been chosen as a prototype for rural American health care. They are already using evening and Saturday hours to meet the workload demand and are considering Sunday hours. The clinic also has a good pharmacy program and an exemplary eye care program.

The visiting Commissioners believed that there is an urgent need in the market for two new CBOCs. Distance is the main issue, with clinics now being 100 miles away for some veterans. Only 52 percent of veterans have primary care access in Montana.

#### Other VISN 19 Issues

The Salt Lake City facility is "maxed out" for space and needs to move functions out to make room for specialty care. Consequently, the VISN is looking for CBOCs. Fort Harrison,

Montana, also has a space deficit. Fort Sheridan has proposed contracting as a solution to its workload problem. The Draft National Plan proposes to send the patients to Denver and Salt Lake City but the VISN questions the capacity of these facilities to absorb the workload and also questions the great distances involved.

## **VISN 23 – Iowa, North Dakota, South Dakota, Minnesota and Nebraska**

### Presentation of Data and Issues

The Commissioner who led the VISN 23 discussion noted that this VISN was formerly two VISNs – VISN 13 and VISN 14. The primary characteristic of the VISN is that it has large states with mostly rural populations. Hearings were held in Minneapolis, Minnesota and Omaha, Nebraska.

The big issue in this VISN is *access*. North Dakota, for example, is the lowest area in the country for providing access at 37 percent for primary and hospital care. The VISN proposed setting up CBOCs to improve access. The Draft National Plan provides none because the enrollee population is not large. Local people did show up at the hearings to request a CBOC in their town. He said the Commission should recommend that the VISN get a modest number of new CBOCs. The only options available are to contract out medical care or stabilize patients and ship them to Minneapolis or Omaha.

A Commissioner asked what fraction of patients VA would pay for locally if it didn't stabilize and transport them. Another Commissioner said "very few" because the problem would have to be service-connected for VA to pay.

### Small Facility Issues

One small facility issue is Hot Springs, South Dakota. This facility would qualify as a critical access hospital under any criteria. It is a very remote facility, the local community hospital is not accredited and it is expensive to send patients to Rapid City. There is a state veterans nursing home and a dom on the same site. It is recommended to agree with the proposed designation of the facility as a critical access hospital.

A second Commissioner said there is a very high concentration of veterans in that geographic area. He agreed that it makes sense to keep the facility open as a very small hospital.

Another Commissioner suggested this proposal should be reviewed in conjunction with the other critical access hospital proposals. He said the Commission does not need to make the decision today.

Another small facility issue is St. Cloud, Minnesota. This facility has been sending its acute inpatient care workload to Minneapolis. Analysis shows that it would cost less to maintain the acute inpatient care medicine beds in St. Cloud than to ship patients to Minneapolis. However, it is recommended that the Commission not get involved in decision-making at this level.

The Commission was advised that the inpatient facility has been closed for two years. VA is contracting for half the patients there locally and sending the other half to Minneapolis. That

contracting is \$800,000 more expensive than doing the work in house. Several Commissioners questioned the comparability of the data involved, noting that it would be important to calculate the costs correctly.

### Knoxville-Des Moines Consolidation

The Commissioner next summarized the proposed transfer of inpatient care at the Knoxville facility to Des Moines. He said the proposal would require building new nursing home beds and possibly other facilities at Des Moines to accommodate the workload. The Commission's concern was that patient care not be adversely affected during the consolidation process.

A second Commissioner observed that the person in charge of inpatient psychiatry at Knoxville is a well-respected individual, and he favors the move. VA will need to be sure that it has enough nursing home capacity after the work is contracted out.

Another Commissioner asked if Knoxville would become only an outpatient facility. The answer given was that it would.

### Other VISN 23 Issues

An issue in Minneapolis is that there is no spinal cord injury program now. The Plan proposes to establish one. A Commissioner questioned whether there was sufficient workload there to justify building 30 beds, which is the optimum size for an SCI facility.

In Omaha, the VISN is working on a joint venture with DoD to establish a CBOC at Offutt Air Force Base.

## **VISNs 21 and 22 – California, Hawaii and Nevada (Part)**

### Presentation of Data and Issues

#### Las Vegas Discussion

In VISN 22, the Draft National Plan proposes to build a new hospital and multi-specialty outpatient clinic in Las Vegas. The big issue is the lack of inpatient care for veterans. Veterans now receive care at a jointly-operated facility at Nellis Air Force Base, which is under the overall command of the Air Force. To expand its capacity in this fast growing area, VA established 10 clinics in the Las Vegas region.

One problem with the joint arrangement is that the Air Force has informed the VA that it is expecting a new wing to be assigned to Nellis and, when this occurs, that it will need all of its beds and may walk away from the current VA-DoD sharing arrangement. However, the local DoD Commander says there is room to add new beds on campus. VA is proposing to build a new hospital.

Both the local Commander and Dr. Chu, the DoD Under Secretary, have said that building a new hospital is a bad idea. The current arrangement is a model arrangement and one that supports the

President's management initiatives. It is also consistent with the recommendations of the President's Task Force.

VA had no inpatient care in southern Nevada before the arrangement with Nellis. Security and access at Nellis are an issue, but the two agencies are dealing with them now. At the hearing, a local Congresswoman testified that she had lined up Congressional support for building the new hospital. This complicates the issue somewhat.

One Commissioner said the Commission should deal with the data, not the politics – just let the politics take its course. He said he is more troubled by the proposals to build two new hospitals in the VA system – one at Las Vegas, where the data doesn't support the proposal, and one at Orlando, which isn't where there is the biggest gap in Florida. He thinks the Commission needs to step back and take another look.

A second Commissioner asked about the downside of walking away from the joint arrangement at Nellis. He is concerned about the message VA would send by walking away from a collaborative arrangement. The Commissioner leading the discussion said the downside mainly involves the loss of opportunity to share things like food service, laboratories and other support functions.

Another Commissioner pointed out that the DoD person who would say things that the Network did not want the Commission to hear was not even invited to the hearing until the night before.

One Commissioner said the bed gap is so small that it could easily be accommodated by Nellis. The real problem in his mind is that there is no room next to the hospital for the new mega outpatient center. He said the number of patients in Las Vegas does not suggest the need for a new hospital.

It was suggested that the VA concept is to locate everything in the Las Vegas area together – off base and in the community.

A Commissioner commented that Dr. Roswell had agreed the new facility could be built at Nellis.

Another Commissioner said there was not one aspect of the VA proposal that he finds reasonable. He thinks the Commission should recommend that VA continue the sharing relationship with Nellis, expanding as needed. The outpatient clinic and nursing home should be built off base on a separate campus.

Discussion among several Commissioners indicated that there is not enough room on the Air Force base for all of the facilities VA wants to build in Las Vegas. Additionally, the outpatient clinic would bring a lot of civilian traffic onto the base and it may be better to put the clinic in the community where people live. A Commissioner noted that such a solution would represent a “win-win” solution for both VA and DoD – the sharing arrangement would be continued plus VA would get a new outpatient clinic. Another Commissioner pointed out that VA would lose the advantages of consolidation under this arrangement.

It was also noted that the Medical School, which is now located in Reno, might be willing to come down to Las Vegas, but that the matter is a political issue.

The consensus of the Commission is that it is important to continue the sharing arrangement with DoD at Nellis Air Force Base.

### Long Beach Discussion

In this market, all the gaps have been met – the VA has enough hospitals in Southern California to meet the demand.

The big issue is the VA property in Brentwood. Local interests do not want VA to dispose of the property because they are afraid it will be used for shopping centers and similar developments. There is a lot of land there; the land has an oil well on it.

Further, under the terms of the initial acquisition, the land reverts to the deeding family if anything other than health care for veterans takes place there. Under the Plan, part of the land will be used for a VA cemetery and part for a state nursing home.

A Commissioner said the real issue was the planning process that was used to decide how the land would be used. The VISN put together an all-Network task force. There were no consumers on it, so the process was not inclusive. Noted is that the purpose of realignment is to enhance services. There is no enhancement of service anywhere in this proposal.

Next discussed was the proposal to establish a new 24-bed Blind Rehabilitation Center in Long Beach. The stakeholders want the Center to be in Los Angeles, but the VISN says there is more room at Long Beach. It was suggested that it is a local call and that Commission should go with the VISN recommendation on this matter.

Long Beach has a lot of old property that it acquired after World War II. There is a lot of high-value property. If VA disposes of the property it won't have to pay to maintain it.

The Plan envisions a new outpatient clinic in the Laughlin, Nevada-Yuma City area that would involve cooperation between two Networks. There has been insufficient collaboration on this matter and the Commission should encourage the VISNs to do more.

It was learned during the site visits that the VISN is planning an enhanced use leasing project at Sepulveda to develop a golf course on the property that would generate revenue. It was asked whether this is in the Plan. A Commissioner said VA should just dispose of the property.

One Commissioner noted that the Plan calls for adding 100 new spinal cord injury beds in an area that has 400 vacant SCI beds now. He asked that the staff check out the reason for this.

### Livermore Discussion

In VISN 21, the Draft National Plan calls for closing the Livermore campus in California and transferring the services offered there to Menlo Park and to CBOCs. There are several issues. One is moving the nursing home beds to Menlo Park; another is the location of new CBOCs. The hearing was well attended.

A Commissioner spoke to the Livermore proposals. He said the facility is located east of San Francisco. What is there now is primarily a nursing home and an outpatient clinic. The Plan proposes to close the campus. VA already has an outpatient clinic in Stockton and the Plan would strengthen it and open a new clinic between Livermore and San Francisco. The 80 nursing home beds at Livermore would be moved to Menlo Park, which now has 120 nursing home beds, and a new nursing home would be built. The remaining Livermore patients – some 60-70 patients – would be taken care of through contracting out to the community.

Most Livermore patients come from Stockton. This means that the move to Menlo Park could be a problem since it would be farther away from relatives. Concern was raised as to whether VA would actually be able to contract out services for the remaining patients and with regard to the nursing home industry in California. A Commissioner said he would like to see data on the cost-benefit aspects of keeping a facility in Livermore before the Commission makes a decision.

Another Commissioner said the facility is located on prime land. He is empathetic with the local people who want to keep the nursing home in the community.

There is also an Alzheimer's unit at Livermore and the facility has been upgraded for seismic safety. This suggests VA might want to keep the nursing home part of the property there and dispose of the rest. Also noted is that contracting out nursing home care does not meet the legal requirement that VA not change the capacity of VA nursing home beds.

Another Commissioner said the VISN had no real plan – just “contract out.” He said he is not sure there is the capacity locally to contract out the number of beds as proposed in the Plan.

Noting that the Livermore proposal is a realignment, the Commission will wait for new data. But if the data supports it, one Commissioner indicated he would want to keep the nursing home there. Another Commissioner noted it is an access issue, not a care issue. He also thinks VA should build the new outpatient clinic closer to the freeway and dispose of the other parts of the campus.

### CBOCs

The Commission heard from representatives for the Pacific Islands and American Samoa during the hearings. A new CBOC is already underway on Guam in connection with the new Navy hospital there. The representative from American Samoa said the data on that location is bad and a CBOC is really needed there, contending there are 5,000 veterans on Samoa where the data show only 1,000. There was also a proposal for a new CBOC on the other side of Oahu from Honolulu. He noted that there is not a very strong case for this proposal.

The sense of the Commission is that it will review the possible CBOC for American Samoa when it reviews the overall CBOC proposals. In the Palo Alto area, two new CBOCs are associated with the Livermore proposal and should be supported, but one should be built closer to the freeway.

After thanking the Commissioners and staff for their work during and since the hearings, Chairman Alvarez adjourned the meeting.