

# CARES Commission



## Capital Asset Realignment for Enhanced Services

February 2004

REPORT TO THE

SECRETARY OF VETERANS AFFAIRS





Department of Veterans Affairs  
CARES Commission

*February 12, 2004*

*The Honorable Anthony J. Principi  
Secretary of Veterans Affairs  
Washington, DC 20420*

*Dear Mr. Secretary:*

*We are pleased to submit the Capital Asset Realignment for Enhanced Services (CARES) Commission's report for your consideration. This report, in line with our charter, contains recommendations, developed after a thorough review of the Under Secretary for Health's Draft National CARES Plan (DNCP) and after seeking the views of veterans and stakeholders across the country, regarding the realignment and allocation of capital assets necessary to meet the demand for veterans health care services over the next 20 years.*

*Our recommendations will assist you in enhancing access to care for more veterans, while ensuring that the integrity of VA's health care and related missions is maintained, and any adverse impact on VA staff and affected communities is minimized.*

*Guided by your leadership, the Under Secretary, the NCPO and many hundreds of VISN personnel, veterans and stakeholders participated in the most comprehensive assessment ever undertaken by VA to determine the capital infrastructure needed to provide modern health care to VA's current and future enrollees. We also want to take this opportunity to applaud the VA for undertaking this massive effort. The Commission's work could not have been possible without the assistance of those in VA who contributed to the early stages of CARES. The VHA, through its National CARES Program Office (NCPO), took special efforts to inform the Commission, during its early months, of the work and methodology NCPO used to commence this mission. The Commission recognizes and commends the conscientious and comprehensive planning effort that culminated in the August 2003 issuance of the DNCP.*

*The methodology developed for the CARES process will serve as a strategic resource for years to come on managing and realigning capital assets nationwide. In particular, this blueprint, with the refinements brought by the Commission's review, provides the underpinnings for an approach for medical care appropriations to more appropriately be used for providing direct medical care to our nation's veterans, rather than for maintaining outdated or underutilized infrastructure. Moreover, VA, by establishing a sound approach to realigning assets, has moved into a leadership role among the other government agencies confronting similar issues.*

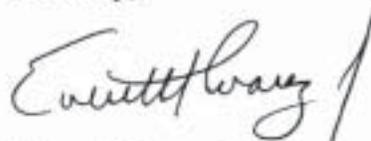
*We conducted 81 site visits to VA and DoD medical facilities and State Nursing Homes, 38 formal public hearings at the 20 VISNs and held monthly meetings since February 2003. These efforts enabled the Commission to develop an appreciation for the challenge that NCPO and the VISNs had faced in applying the model and developing market plans. The time they spent involving veterans and local stakeholders in identifying and gaining understanding for resolutions to the myriad of complex issues confronting VA will continue to be invaluable in the further development of the CARES process. Moreover, their actions provided a sound foundation for the Commission's work. The Commission recognizes that the DNCP proposals they advanced also forms the basis for making significant and far reaching changes in the delivery of health care to our nation's veterans.*

*The decision to evaluate how best to realign VA's capital assets, while initiated in response to concerns raised by the General Accounting Office report on underutilized vacant space (1999) and Congressional expectations that followed, evidences VHA's and VA's recognition of the need for a systematic assessment of future capital needs in relation to current assets. While it would likely result in the need for change, which does not always provide immediate comfort to those affected, it is essential to ensuring that VA can continue to serve the health care needs of those who have served in our military.*

*We believe that our recommendations support the sound objectives of the CARES process and that they will help you to lead VA to a future that will create better access to health care for more veterans across the country. The recommendations are divided into two main categories. The first sets, found in Chapters 3 and 4, provide the Commission's response to crosscutting and national issues. The second set of recommendations focus on the individual VISNs. Taken together, they provide a strategic approach to respond to the impact of capital assets on the health care needs of our veterans and provide a resource for the continued implementation of CARES.*

*Throughout the Commission's work, we were assisted by a group of dedicated staff who were tireless in supporting every aspect of the Commission's agenda. We thank you for the confidence you have shown in choosing us to undertake this mission. We appreciate the continuing support you have given to our efforts to further the goals of the CARES process.*

Sincerely,



Everett Alvarez, Jr.  
Chairman  
CARES Commission

CARES Commission  
(Capital Asset Realignment for Enhanced Services)

*Submitted  
to  
The Secretary  
Department of Veterans Affairs  
this  
February 2004*

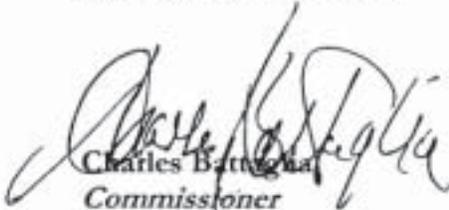
*Approved by:*



The Honorable Everett Alvarez, Jr.  
*Commission Chairman*



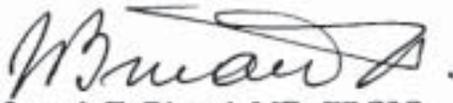
The Honorable Raymond John Vogel  
*Commission Vice Chairman*



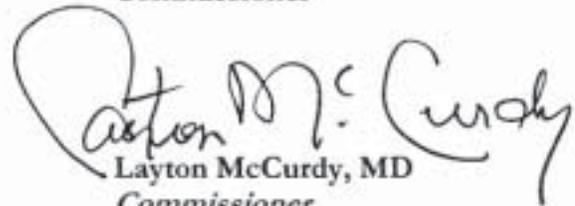
Charles Battaglia  
*Commissioner*



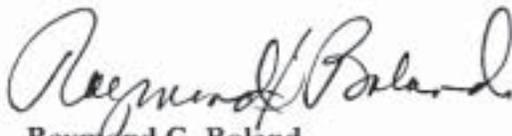
Richard McCormick, PhD  
*Commissioner*



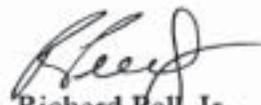
Joseph E. Binard, MD, FRCSC  
*Commissioner*



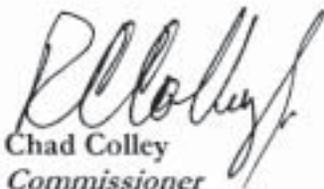
Layton McCurdy, MD  
*Commissioner*



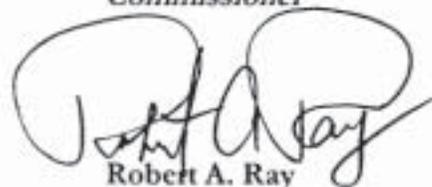
Raymond G. Boland  
*Commissioner*



Richard Pell, Jr.  
*Commissioner*



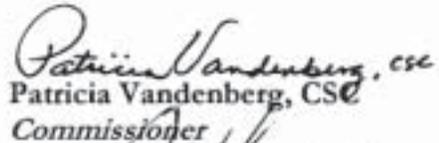
Chad Colley  
*Commissioner*



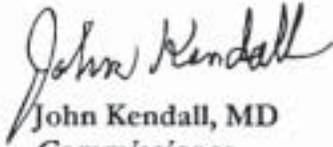
Robert A. Ray  
*Commissioner*



Vernice Ferguson, RN, MA, FAAN, FRCN  
*Commissioner*



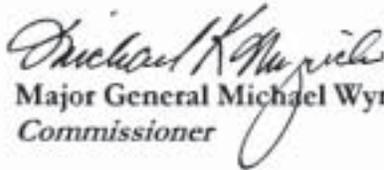
Patricia Vandenberg, CSE  
*Commissioner*



John Kendall, MD  
*Commissioner*



The Honorable J. Krukar Webb  
*Commissioner*



Major General Michael Wyrick, USAF (Ret)  
*Commissioner*



Al Zamberlan, FACHE  
*Commissioner*

## COMMISSION STAFF

Richard E. Larson  
*Executive Director*

### Staff

Ronald Bednarz, Deputy Director  
Dick Fry, Deputy Director  
Carolyn Adams  
Nicheole Amundsen  
William Brew  
Barbara Eberhard  
Randy Estes  
Pamela Graff  
William Judy  
Thomas Keefe  
Shirley Lai  
Sara Lee

Kathleen Collier, Deputy Director  
Rebecca Wiley, Deputy Director  
Calvin Marshall  
Kathryn McBride  
Phyllis McMeekin  
Johnetta McKinley  
Teravy Mol  
Jean Renaker  
Janice Sloan  
Rae Ann Steinly  
Scott Ward  
Susan M. Webman, Counselor

## Contents

---

|  |      |
|--|------|
| <b>Transmittal Letter</b> .....                              | iii  |
| <b>Executive Summary</b> .....                               | ES-1 |
| <b>Chapter 1 CARES Commission Process</b> .....              | 1-1  |
| <b>Chapter 2 Overview</b> .....                              | 2-1  |
| <b>Chapter 3 National Crosscutting Recommendations</b> ..... | 3-1  |
| Facility Mission Changes .....                               | 3-2  |
| Community Based Outpatient Clinics (CBOCs) .....             | 3-20 |
| Mental Health Services .....                                 | 3-24 |
| Long-Term Care .....   | 3-26 |
| Excess VA Property .....                                     | 3-29 |
| Contracting for Care .....                                   | 3-33 |
| <b>Chapter 4 Other National Recommendations</b> .....        | 4-1  |
| Infrastructure and Safety .....                              | 4-2  |
| Education and Training .....                                 | 4-3  |
| Special Disability Programs .....                            | 4-6  |
| VA/DoD Sharing .....   | 4-8  |
| Research Space .....   | 4-10 |
| Care Delivery Innovations .....                              | 4-12 |

**Chapter 5 VISN Recommendations** ..... 5-1

VISN 1, VA New England Health Care System ..... 5-4

VISN 2, VA Health Care Network Upstate New York ..... 5-22

VISN 3, VA New York/New Jersey Veterans Health Care Network ..... 5-36

VISN 4, VA Stars and Stripes Health Care Network ..... 5-56

VISN 5, VA Capitol Health Care Network ..... 5-80

VISN 6, Mid-Atlantic Health Care Network ..... 5-94

VISN 7, Atlanta Network ..... 5-112

VISN 8, VA Sunshine Health Care Network ..... 5-136

VISN 9, VA MidSouth Health Care Network ..... 5-156

VISN 10, VA Health Care System of Ohio ..... 5-180

VISN 11, Veterans in Partnership ..... 5-198

VISN 15, VA Heartland Network ..... 5-218

VISN 16, South Central VA Health Care Network ..... 5-232

VISN 17, VA Heart of Texas Health Care Network ..... 5-252

VISN 18, VA Southwest Health Care Network ..... 5-276

VISN 19, Rocky Mountain Network ..... 5-294

VISN 20, Northwest Network ..... 5-316

VISN 21, Sierra Pacific Network ..... 5-338

VISN 22, Desert Pacific Health Care Network ..... 5-358

VISN 23, VA Midwest Health Care Network ..... 5-384

**Appendix A Glossary of Acronyms and Definitions** ..... A-1

**Appendix B Capital Asset Realignment For Enhanced Services (CARES) Commission Charter** ..... B-1

**Appendix C Comment Analysis** ..... C-1

**Appendix D Data Tables** ..... D-1

**Appendix E Financial Review Summary** ..... E-1

## Executive Summary

---

The Capital Asset Realignment for Enhanced Services (CARES) Commission is pleased to submit its report to the Secretary of Veterans Affairs. This report culminates a year of intensive review of the Department of Veterans Affairs (VA) plans to realign its infrastructure in order to enhance access to health care services for our nation's veterans. This review included 81 site visits to VA and Department of Defense (DoD) medical facilities and State Veterans Homes, 38 public hearings, 10 public meetings, and analysis of more than 212,000 comments received from veterans and stakeholders nationwide. The 16 Commissioners unanimously agree that the CARES process advances VA's efforts to provide quality health care for the veterans it serves.

*The 16 Commissioners unanimously agree that the CARES process advances VA's efforts to provide quality health care for the veterans it serves.*

This report contains the Commission's perspective both on the major issues facing the health care system as a whole and on Veterans Integrated Service Network (VISN)-specific initiatives proposed as part of the Draft National CARES Plan (DNCP).<sup>1</sup>

In its Charter<sup>2</sup>, the Commission was charged with providing an objective, external perspective to the CARES planning process. The Commission was asked to provide specific impartial and equitable recommendations for the realignment and allocation of capital assets to meet the demand for veteran health care services over the next 20 years. The hallmarks of the Commission have been its rigorous review of available information and emphasis on veteran and stakeholder input. The Commission invited and received comments from individual veterans, veteran organizations, local and national labor organization representatives, medical school and other clinical affiliates, DoD representatives,

---

<sup>1</sup> Draft National CARES Plan, released by the Under Secretary for Health on August 4, 2003.

<sup>2</sup> Appendix B, *Capital Asset Realignment For Enhanced Services (CARES) Commission Charter*.

and elected officials across the country. The Commission is grateful to those who took the time and effort to meet with Commissioners, attend hearings, and submit written comments, and it gave serious consideration to this input in developing its recommendations.

*The Commission urges stakeholders and elected officials to view the CARES process from the national perspective of how to best serve our nation's veterans, now and in the future.*

The Commission is dedicated to moving the CARES process forward to make significant and necessary improvements to the VA health care infrastructure. Through its public meetings, site visits, public hearings, informal meetings with individual veterans and stakeholders, and analysis of comments received, the Commission developed an understanding of the complexity of the issues confronting VA and the

significance of the changes proposed in the DNCP. The Commission believes that change is necessary to prepare the system for a new veteran demographic reality and a rapidly evolving approach to health care delivery, including greater reliance on technology and specialty services, as well as long-term care. Responding to these changes requires realigning current resources to ensure that the system will be ready to care for tomorrow's veterans. The Commission urges stakeholders and elected officials when reviewing the proposed realignment of resources to view the CARES process from the national perspective of how to best serve our nation's veterans, now and in the future.

In compliance with its Charter, the Commission formulated its final report based on proposals contained in the DNCP issued by the Under Secretary for Health (USH). This report is divided into two main parts; the first, Chapters 1 through 4, addresses the CARES process and national issues associated with it. The second, Chapter 5, provides the Commission's specific recommendations on individual VISN initiatives as outlined in the DNCP. The Commission applied a standard of reasonableness as its guiding principle in its deliberations on specific proposals. The following six factors were applied:

- ▶ Impact on veterans' access to care
- ▶ Impact on health care quality
- ▶ Veteran and stakeholder views
- ▶ Impact on the community
- ▶ Impact on VA missions and goals
- ▶ Cost to government

In its review of the DNCP and subsequent data provided by the National CARES Program Office (NCPO), the Commission was challenged in its decision-making process most notably by the scarcity of consistently applied data, a lack of uniform supporting documentation, and an absence of a standardized analytic format to assist the Commission in conducting its own analysis and in making specific recommendations.

Nevertheless, the Commission is satisfied that the foundational data collected early in the CARES process was sound, and enabled the Commission to move forward with its review of the DNCP. In light of this, the Commission consolidated and analyzed all information gathered from site visits, hearings, public meetings, and data generated by the NCPO.

With the available information and insight derived from its experience in the VISNs, the Commission used its best judgment, applying diverse expertise and individual experiences to identify issues critical to VA to successfully transform its health care system and make the best recommendations in relation to the future of the VA infrastructure.

Resolution of the complex, system-wide issues confronting VA is essential to achieving the desired changes. Of these, the following issues arose in all or nearly all VISNs and were designated as “Crosscutting Issues.”

- ▶ Facility Mission Changes
- ▶ Community-Based Outpatient Clinics (CBOCs)
- ▶ Mental Health Services
- ▶ Long-Term Care, including Long-Term Mental Health Care
- ▶ Excess VA Property
- ▶ Contracting for Care

*With the available information and insight derived from its experience in the VISNs, the Commission used its best judgment, applying diverse expertise and individual experiences to identify issues critical to VA to successfully transform its health care system and make the best recommendations in relation to the future of the VA infrastructure.*

Facility mission changes and excess VA property relate to the realignment of capital assets. The prioritization and placement of CBOCs and contracting for care issues focus on developing equitable access to quality health care. Similarly, mental health and long-term care issues, which were not fully incorporated into this phase of CARES, deal with providing access to quality services.

The Commission also discusses additional recommendations of national importance that are distinguished from the crosscutting issues in that they are relevant in selected VISNs, rather than in most or all of the VISNs. These are no less significant than the crosscutting issues discussed in Chapter 3. These national issues are:

- ▶ Infrastructure and Safety
- ▶ Education and Training

- ▶ Special Disability Programs
- ▶ VA/DoD Sharing
- ▶ Research Space
- ▶ Care Delivery Innovations

*The Commission determined that the CARES model provided a reasonable analytical approach for estimating VA enrollment, utilization, and expenditures.*

The balance of the Commission’s recommendations pertains to the major specific initiatives proposed as part of the DNCP for each VISN.

These initiatives, addressed on an individual VISN basis in Chapter 5, include the selection and placement of CBOCs, facility mission changes, infrastructure improvements, and new hospital construction.

### **CARES MODEL**

The CARES model is the foundation for projections and proposed solutions set forth in the DNCP. The Commission determined that the CARES model provided a reasonable analytical approach for estimating VA enrollment, utilization, and expenditures. The Commission deferred final acceptance of the projections, however, until assured that the revised model would include necessary modifications, including a sensitivity analysis that would establish a “lower-bound” estimate of enrollment, and use of data on enrollment rates based on a 30-month period rather than the 13 months used in the model. This lower-bound sensitivity analysis was not conducted prior to the completion of the Commission’s work, and a later version of the model relied on a 12-month timeframe instead of the recommended 30 months of data.

As a result, the Commission strongly recommends that initiatives in the DNCP requiring significant capital investment not be approved without a rigorous re-examination of the sustainable enrollment base justifying each investment.

### **PROPOSED NEW HOSPITAL CONSTRUCTION**

There were a number of instances where the DNCP proposed or the Commission recommends construction of a new hospital or an immediate study of the construction of a new hospital. The DNCP proposed new construction in Orlando (VISN 8), Denver (VISN 19) and Las Vegas (VISN 22) and proposed studies for Charleston (VISN 7) and Louisville (VISN 9). The Commission concurred with the DNCP proposals for Orlando, Denver, Charleston and Louisville. The Commission did not concur with the proposal for Las Vegas, instead recommending that VA continue partnering with DoD at Nellis Air Force Base. In addition, the Commission recommends that VA conduct a feasibility study of building a single, appropriately sized

medical center to replace the four existing facilities in the Boston area (VISN 1).

## CROSCUTTING RECOMMENDATIONS

### Facility Mission Changes

The intent of the CARES process is to realign resources in order to enhance access to health care services for our nation's veterans. To accomplish this goal, it is critical to eliminate duplicate clinical and administrative services at VA facilities, increase efficiencies, and allow reinvestment of financial savings. The DNCP proposed consolidation of services at 40 facilities – 18 with small workload volume<sup>3</sup> and 22 within close geographic proximity of other facilities or with multiple campuses.<sup>4</sup> The Commission used the term “facility mission changes” to describe all recommended changes to facilities.

The Commission reviewed each mission change proposal using its guiding principle of reasonableness and the factors highlighted previously. Access to quality care was the main driver in the Commission's analysis of these mission changes.

A complete, detailed listing of the Commission's responses to the DNCP proposals for facilities with potential mission changes can be found in Chapter 3, with specific initiatives discussed in Chapter 5. In summary, however, the DNCP proposed closure of inpatient services at some facilities, realignment of services at medical centers with multiple campuses, and actions, including further study, at certain other facilities. The following paragraphs outline these proposals and the Commission's responses.

*Closure of inpatient services* – The DNCP proposed closure of inpatient hospital services or closure of existing services, including long-term care services, at three facilities (Bedford, MA; Canandaigua, NY; and White City, OR). The Commission did not agree with any of these plans as submitted. As to Bedford, the Commission recommends a more thorough study of the feasibility of building a single, replacement medical center in the Boston area.

*The Commission reviewed each mission change proposal using its guiding principle of reasonableness. Access to quality care was the main driver in the Commission's analysis of these mission changes.*

<sup>3</sup> The total of facilities discussed as small facilities differs slightly from that shown in the DNCP in Table 8.2, Small Facility Recommendations, which lists 19 facilities. Two of those included in Table 8.2 – Knoxville and Des Moines, IA – are two campuses of one health care system and the consolidation of services from Knoxville to Des Moines is included in Table 9.1, Campus Realignment Proposals. These facilities are not included as small facilities. In additions, Roseburg, OR, is described as a small facility in the VISN 20 Executive Summary in the DNCP, but was not included in Table 8.2.

<sup>4</sup> The total of facilities discussed as proximity or campus realignments differs from that shown in the DNCP in Table 9.1, Campus Realignment Proposals, which includes 26 facilities. Four of the facilities included in Table 9.1 – Montrose, NY; Kerrville, TX; Walla Walla, WA; and Hot Springs, SD – are also included in Table 8.2 as small facilities and are discussed under that category in this report.

*Campus realignments* – The DNCP proposed that services be realigned at 11 medical centers with multiple campuses in order to cease 24 hour operations at one campus (Hudson Valley Health Care System's (HCS) Montrose Campus; Pittsburgh's Highland Drive Campus; Lexington's Leestown Campus; Cleveland's Brecksville Campus; Northern Indiana HCS's Fort Wayne Campus; Biloxi's Gulfport Campus; Central Texas HCS's Waco Campus; South Texas HCS's Kerrville Campus; Portland's Vancouver Campus; Palo Alto's Livermore Campus; and Central Iowa HCS's Knoxville Campus). The Commission agreed with the plans for six of these realignments (Highland Drive, Brecksville, Fort Wayne, Gulfport, Kerrville and Knoxville) and did not agree completely with five plans (Montrose, Leestown, Waco, Vancouver and Livermore).

*Small facilities* – With respect to facilities reviewed as small facilities, the DNCP proposed closure of all acute inpatient services at three facilities (Butler, PA; Saginaw, MI; and Walla Walla, WA). The Commission concurred.

The DNCP further proposed that seven small facilities or campuses retain all of their current acute inpatient services (Altoona, PA [until 2012]; Beckley, WV; Poplar Bluff, MO; Prescott, AZ; Cheyenne, WY; Grand Junction, CO; and Hot Springs, SD). The Commission agreed that four facilities (Prescott, Cheyenne, Grand Junction and Hot Springs) should retain all services. The Commission did not concur with the DNCP on three facilities (Altoona, Beckley, and Poplar Bluff). As to Altoona, the Commission recommended closure of all hospital acute services as soon as reasonable. As to Beckley, the Commission recommended closure of all acute inpatient services as soon as reasonable. As to Poplar Bluff, the Commission recommended a full cost-benefit analysis of sustaining inpatient services versus contracting for such services, followed by a decision on closing inpatient services.

The DNCP proposed closing inpatient surgery but retaining inpatient medicine at Erie, PA. The Commission recommended that all acute care beds be closed as soon as reasonable. The DNCP proposed closing inpatient surgery at Lake City, FL. The Commission did not concur. The DNCP proposed that surgery beds at Dublin, GA be transitioned to observation beds with complex, non-urgent or non-emergent surgery referred to other VAMCs and emergent surgery referred to community hospitals on a contract basis. The Commission concurred. The DNCP proposed that inpatient surgery and ICU beds at Muskogee VAMC be closed. The Commission concurred and further recommended that VA conduct a more thorough study of meeting the health care needs of the population through the Muskogee VAMC versus using community resources in the Muskogee/Tulsa area. The DNCP noted that converting surgical beds to 24-hour surgical observation beds is underway at Roseburg, OR. The Commission concurred. The DNCP proposed closing acute medicine beds at St. Cloud, MN, but retaining acute psychiatric beds. The Commission concurred.

*Further study* – The DNCP proposed that a plan be developed to consider the feasibility of consolidating acute inpatient care from the Manhattan campus of the NY Harbor HCS to the Brooklyn campus. The Commission concurred. The DNCP proposed studying the feasibility of realigning the campus footprint of the Uptown Division of the Augusta VA Medical Center (VAMC) and consolidating some services from the Uptown Division to the Downtown Division. The Commission did not concur. The DNCP indicated that the proposal to convert the Montgomery campus of the Central Alabama HCS to an outpatient-only facility requires further study. The Commission concurred. The DNCP proposed studying the feasibility of closing the Big Spring VAMC facility. The Commission concurred.

### Community-Based Outpatient Clinics (CBOCs)

Access to outpatient care, defined as the time veterans must travel to receive care, is an important component of the CARES process. VISNs proposed 242 new CBOCs – 175 to address outpatient access issues and 67 to address issues related to increasing workload capacity for primary and mental health care, as well as space deficits at VAMCs.<sup>5</sup>

The DNCP divided the 242 proposed CBOCs into three priority groups to curtail new demands on the system. This methodology generally led to CBOCs in rural areas being placed in the second priority group and left certain large markets with growing outpatient demand out of priority group one.

*This methodology generally led to CBOCs in rural areas being placed in the second priority group and left certain large markets with growing outpatient demand out of priority group one. The Commission found that VA's rationale for prioritizing the implementation of new CBOCs was to control new demand for care, which disproportionately disadvantages rural veterans and is contrary to the goal of CARES.*

The Commission found that VA's rationale for prioritizing the implementation of new CBOCs was to control new demand for care, which disproportionately disadvantages rural veterans and is contrary to the goal of CARES.

The Commission recommends that the Secretary and USH utilize their authority to establish new CBOCs within the VHA medical appropriations without regard to the three priority groups for CBOCs outlined in the DNCP. VISNs should set priorities for the establishment of new CBOCs based on VISN needs to improve access and respond to increases in workload. Moreover, VISNs should be able to address capacity issues, to relieve space deficits at the parent facility, by establishing new sites of care, provided the VISNs have the resources necessary to do so.

<sup>5</sup> Updated CBOC listing provided to the CARES Commission by the National CARES Planning Office (NCPO) on December 11, 2003.

## Mental Health Services

The CARES model used private sector actuarial data to predict the need for mental health services, but it became clear that these data did not accurately reflect VA utilization, resulting in an underestimation of future outpatient mental health needs. The Commission found that the CARES outpatient projections underestimated demand by at least 34 percent.<sup>6</sup> The Commission understands that the major flaws in the model for projecting these mental health needs have been identified and are being corrected, and that revised projections will be rerun in the near future.

For inpatient mental health care, the Commission found that VA's inpatient psychiatry database did not separate acute and long-term patients, and the model considered length of stay as the determining factor,

*Flaws in the model for projecting these mental health needs have been identified and are being corrected.*

arbitrarily using 75 days as the maximum for an acute stay. The Commission understands that the forecasts for acute inpatient psychiatric demand are being reworked, using 45 days, a figure more in line with private sector standards, as the cutoff for defining an admission as acute.

The Commission also noted significant variation in the current provision of mental health services across VISNs, including in CBOCs.

The Commission recommends that the current projections for outpatient mental health services and acute psychiatric inpatient care be reworked utilizing corrected VA data, and that VISNs quickly identify or revise plans to address gaps in service, which should be integrated into the ongoing CARES process.

## Long-Term Care (LTC)

Long-term care (nursing home, domiciliary, and non-acute inpatient and residential mental health services) was not included in the current CARES projections. Despite this, the DNCP included several initiatives that directly impact these services.

The Commission found that developing a model for the deployment of LTC beds across VA is a complex undertaking that VA has yet to complete. Furthermore, VA has not developed a consistent rationale for the placement of LTC units. It is also clear that strategic planning for LTC has not adequately addressed the needs of aging, seriously mentally ill patients for whom community resources are scarce. Finally, DNCP proposals for the movement of domiciliary beds are inconsistent, at times recommending that programs

<sup>6</sup> VSSC KLF Menu Database, *Workload: Outpatient, Clinic Stops and Persons*, ending FY 2001.

designed to rehabilitate urban homeless veterans be moved away from the urban areas from which they draw their patients, when, in fact, they should be located in the urban area where the patients most likely will reside.

As discussed in Chapter 5, the Commission recognizes that there are VISN-specific proposals for renovating existing LTC and chronic psychiatric care units that are needed and should proceed. No actions to replace existing LTC capacity or expand it, however, should proceed until VA develops a strategic plan for the deployment of LTC services, including for the LTC of the seriously mentally ill. In developing the strategic plan, VA should enhance collaborations with states to leverage VA and other public funding through the State Veterans Home program.

### Excess VA Property

Implementation of the DNCP proposals is projected to result in a 42 percent reduction in vacant space in VA from 8.5 million square feet in FY 2001 to 4.9 million in FY 2022.<sup>7</sup> The DNCP outlines demolition and divestiture as the primary methods to reduce vacant space; but also relies heavily on the enhanced use leasing (EUL) process. The EUL process allows VA to lease underutilized or unused property to an outside entity as long as the agreement provides a benefit to veterans.

The Commission understands the potential value in the EUL process, but found that the planning and the process, as it currently exists, have been fraught with delays that have led to significant lost opportunities. The Commission notes that there are viable options other than the EUL process – such as outright sale of the asset or transferring the asset to another public entity – that were seldom considered in the DNCP.

The Commission found that maintaining excess buildings and land requires VA to utilize medical care appropriations that could otherwise be used to provide direct medical care. Historic designations of VA facilities often impede disposition of the property. The 42 percent reduction in vacant space by FY 2022, as proposed in the DNCP, seems low. Without a complete explanation, the Commission cannot thoroughly assess this figure. Finally, the DNCP relies heavily on an EUL process that is not fully understood by VISNs and is in need of organizational improvement.

*The Commission found that maintaining excess buildings and land requires VA to utilize medical care appropriations that could otherwise be used to provide direct medical care.*

<sup>7</sup> DNCP, *Chapter 12: Reducing Vacant Space*, page 2, available from [<http://www1.va.gov/cares/docs>].

The Commission recommends that VA develop a more efficient process, perhaps even a separate organization, to dispose of excess space and land; ensure that adequate expertise in the disposal of capital assets is available at the local level; ensure that the EUL process is streamlined; and seek a separate appropriation to stabilize and maintain historic property.

### **Contracting for Care**

In the past decade, VA transformed from a system of discrete medical centers to a health care system marked by improving access by providing services closer to where veterans reside. The Veterans Health Administration (VHA) has used contracting as one vehicle for improving access to care.

The benefits of contracting for care in the community are: 1) it can add capacity and improve access faster than can be accomplished through a capital investment; 2) it provides flexibility to add or discontinue services as needed; and 3) it allows VA to provide services in areas where the small workload may not support a VA infrastructure, such as in highly rural areas. Some stakeholders, however, believe that contracting for care shifts VA's role away from that of a health care provider.

The Commission concurs with the DNCP proposals to utilize contracts for care in the community to enhance access to health care services. VA must ensure that contracting is feasible and that the local community can effectively provide the necessary services.

## **OTHER NATIONAL RECOMMENDATIONS**

### **Infrastructure and Safety**

VHA identified 63 sites requiring seismic correction.<sup>8</sup> Many of these are large facilities located in high population density areas. Of this total, the DNCP prioritized 14 sites that require immediate seismic strengthening. The total funding requirement for these facilities is \$560.8 million.<sup>9</sup>

Congress appropriates funding to VA for construction-related purposes using two funding accounts. One is for major construction projects where the estimated cost of the project is \$4 million or higher, and the other is for minor construction projects with estimated costs under \$4 million. Over the past few years, Congress has appropriated funding for minor construction projects, but has withheld sufficient funding for major projects pending the outcome of CARES.

<sup>8</sup> DNCP, *Chapter 11: Capital Investments (Safety and Environment)*, page 3, available from [<http://www1.va.gov/cares/docs>].

<sup>9</sup> DNCP, *Chapter 11: Capital Investments (Safety and Environment)*, page 3, available from [<http://www1.va.gov/cares/docs>].

The Commission recommends that patient and employee safety be the highest priority for VA CARES funding. VA should seek the appropriation of necessary funding to correct documented seismic/life safety deficiencies as soon as possible.

## Education and Training

Education and training for health care students and residents is one of the four statutory missions of VHA. In FY 2002, VA trained more than 76,000 students, including 16,000 medical students, 32,000 nurses and associated health trainees, and 28,000 medical residents.<sup>10</sup>

VA has undergone a significant transformation over the past decade from a primarily inpatient care system to a system with significant reliance on community-based outpatient delivery of care.

*The Commission recommends that patient and employee safety be the highest priority for VA CARES funding. VA should seek the appropriation of necessary funding to correct documented seismic/life safety deficiencies as soon as possible.*

Generally, however, medical schools and other clinical affiliates have not made the transition from the traditional inpatient teaching modalities to community-based outpatient care educational programs in VA. VA and its medical school and other clinical affiliates need a systematic approach to addressing this issue.

The Commission recommends that VA and its medical school, nursing school, and other clinical affiliates develop a plan to address adding a community-based outpatient component to VA's education programs.

VA established a policy for VA affiliations with medical schools through Policy Memorandum 2.<sup>11</sup> VA provides training opportunities for medical students and medical residents under direct supervision of VA clinicians who hold joint appointments in the affiliated medical school and with the VA facility.

No comparable policy exists for nursing education or other health professions.

The Commission recommends that VA establish national policy guidance for schools of nursing comparable to the medical school model in Policy Memorandum 2, and actively promote nursing school affiliations, as well as affiliations with other health profession educational institutions as appropriate.

<sup>10</sup> *Office of Academic Affiliations: Graduate Medical Education; Associate Health Education*, Department of Veterans Affairs.

<sup>11</sup> *Policy in Association of Veterans' Hospitals with Medical Schools*. First published January 30, 1946. Available at VA Manual 8 (M8), Part I, Chapter 2, Appendix 2-D. (November 8, 1989), it is commonly referred to as "Policy Memorandum Number 2."

## Special Disability Programs

The DNCP proposes expansion of both the Spinal Cord Injury/Disorders (SCI/D) and Blind Rehabilitation programs in order to sustain current services and to respond to anticipated increases in demand for these services as these special populations age. The Commission evaluated each DNCP proposal for special disability programs.

The proposed addition of four new SCI centers and additional beds in two other locations will benefit many veterans. There is, however, no strategic approach to balancing the mix of acute and long-term care beds. Current occupancy rates among VA facilities with SCI/D units range

from approximately 52 percent to 98 percent.<sup>12</sup> In spite of current occupancy rates, the Commission's hearing record indicates that veterans are currently waiting for SCI/D beds. This may be a result of an inefficient mix of SCI/D beds, staffing shortages, or of certain SCI/D units being located in less than optimal geographic locations.

*The Commission's hearing record indicates that veterans are currently waiting for SCI/D beds. This may be a result of an inefficient mix of SCI/D beds, staffing shortages, or of certain SCI/D units being located in less than optimal geographic locations.*

VA's Blind Rehabilitation Centers (BRCs) are structured to serve blinded veterans in an inpatient environment. The proposed addition of two BRCs in VISNs 16 and 22 will assist blinded veterans throughout the country.<sup>13</sup> Inpatient settings are not the only solution, however. A more appropriate response to serving many blinded veterans is to provide rehabilitation and retraining in community or home settings.

Specific Commission recommendations on the treatment of special disability programs are included in the VISN summaries in Chapter 5. Overall, the Commission recommends that VA ensure coordination among VISNs with regard to the placement of special disability centers to optimize access to care for veterans. VA should develop new opportunities to provide blind rehabilitation in outpatient settings close to veterans' homes. In addition, VA should conduct an assessment of acute and long-term bed needs for SCI centers to provide the proper balance of beds to best serve veterans and reduce wait times.

<sup>12</sup> VSSC KLF Menu Database, *Workload: Inpatient Occupancy Rates*, as of the end of FY 2002.

<sup>13</sup> Rebecca Vinduska, Director of Governmental Regulations, Blinded Veterans Association, Written Testimony submitted at the CARES Commission Meeting in Washington, DC, on October 7, 2003, page 3.

## VA/DoD Sharing

In the DNCP, there are 75 collaboration and sharing opportunities for VA/DoD sharing.<sup>14</sup> Additionally, the DNCP highlights VA's mission to provide support to DoD in times of conflict or national disaster. During site visits and hearings, the Commission reviewed a wide range of VA/DoD sharing initiatives across the country and found varying degrees of support and momentum for their completion. Both the Congressional Commission on Servicemembers and Veterans Transition Assistance, in its 1999 report, and the Presidential Task Force to Improve Health Care Delivery for Our Nation's Veterans, in its 2003 report, focused on the value of increased VA/DoD cooperation and on the need to establish support mechanisms for such cooperation. As noted in the 2003 report of the Presidential Task Force, it is vital that VA/DoD leaders establish organizational cultures and mechanisms that support collaboration, improve sharing, and coordinate the management and oversight of health care resources and services, with clear accountability for results.<sup>15</sup>

The Commission recommends that VA/DoD collaboration be one of the first considerations in addressing health care needs in a local area. VA and DoD leadership should provide authority, accountability, and incentives to local managers to encourage and facilitate sharing activities that improve health care delivery and control costs. VA and DoD should also institute policies that prevent changes in local VA and DoD leadership from unilaterally canceling existing or proposed sharing initiatives. Furthermore, VA must carefully review all CARES initiatives to ensure protection of VA's support mission to DoD.

*The Commission recommends that VA/DoD collaboration be one of the first considerations in addressing health care needs in a local area.*

## Research Space

VA's research mission is to advance knowledge and promote innovations that improve the health and care of veterans. This mission is carried out through the support of scientifically meritorious and VA-relevant research and development.<sup>16</sup> Research opportunities are a crucial mechanism for recruiting and retaining highly qualified clinicians who, in addition to conducting research, provide critical clinical care and supervisory services at VA facilities.

<sup>14</sup> DNCP, *Chapter 14: Partnering with the Department of Defense*, page 3, available from [[http://www1.va.gov/cares/docs/DNP\\_ch14.pdf](http://www1.va.gov/cares/docs/DNP_ch14.pdf)].

<sup>15</sup> *President's Task Force to Improve Health Care Delivery for Our Nation's Veterans*, Final Report 2003, page 6.

<sup>16</sup> VHA Directive 1204, *Veterans Health Administration Health Services Research and Development*. April 15, 2002, page 2.

The DNCP includes proposals for more than 20 research leases, new construction, and EUL proposals. Testimony in those VISNs where major research efforts are underway indicated major challenges in obtaining adequate research space. Testimony also addressed the deficit in projected research space needs identified in the DNCP.

The Commission concurs with the proposals in the DNCP for enhancing research space.

### Care Delivery Innovations

VA has undertaken a number of changes in care delivery designed to enhance access to services. Primary among them are CBOCs, discussed above. The use of advanced practice nurses and telemedicine are two other illustrations of new approaches to delivering care. The Commission observed these to be effective tools to enhance access to care and leverage clinician productivity.

*The Commission supports VA plans to make CARES an integral and ongoing component of VA's approach to planning and executing its missions. The Commission recommends the Secretary establish an independent advisory body to monitor and advise the Secretary on the ongoing integration of CARES into VA's strategic planning process.*

The Commission recommends that VA encourage the use advanced practice nurses and telemedicine to enhance access and quality of care, and urges wider application of these resources throughout VA.

### THE FUTURE

The CARES process advances VA's efforts to ensure the continued availability of quality health care for the veterans it serves. An appropriate process for self-assessment and renewal is vital for any quality organization in a dynamic environment such as health care. The Commission supports VA plans to make CARES an integral and ongoing component of VA's approach to planning and executing its missions. The Commission recommends the Secretary establish an independent advisory body, with appropriate charter and authority, to monitor and advise the Secretary on the ongoing integration of CARES into VA's strategic planning process.